

**Trust Board Meeting in Public**  
**Thursday 27 March 2024, 10:00 – 14:20**  
**Seminar Rooms 4 & 5, Learning & Research Building, Southmead Hospital**

## A G E N D A

No.	Item	Purpose	Lead	Paper	Time
<b>OPENING BUSINESS</b>					
1.	Welcomes and Apologies for Absence: <i>Apologies: None</i>	Information	Joint Chair	Verbal	10.00
2.	Declarations of Interest	Information	Joint Chair	Enc.	10.01
3.	Volunteer Story (linked to item 10)	Discussion	Chief Nursing Officer	Enc.	10.02
4.	Questions from the Public	Discussion	Joint Chair	Verbal	10.20
<b>STANDING ITEMS</b>					
5.	Minutes: Public Board: 30 January 2025	Approval	Joint Chair	Enc.	10.30
6.	Action Log	Approval	Trust Secretary	Enc.	10.31
7.	Matters Arising	Discussion	All	Verbal	10.32
8.	Joint Chair's Report	Information	Joint Chair	Enc.	10.33
9.	Joint Chief Executive's Report	Information	Joint Chief Executive	Enc.	10.45
<b>KEY DISCUSSION ITEMS</b>					
10.	Volunteer Services Strategic Plan 2025-2028	Discussion	Chief Nursing Officer	Enc.	11.00
11.	Patient First Update	Discussion	Hospital Managing Director	Enc.	11.10
12.	Staff Survey 2024 results	Information	Interim Chief People Officer	Enc.	11.25
<b>BREAK (10 minutes)</b>					11.50
13.	Research and Development Annual Report	Discussion	Chief Medical Officer	Enc.	12.00
14.	South Gloucestershire Joint Health and Well-being Strategy	Discussion	Chief Medical Officer	Enc.	12.15
15.	Operational Plan 2025/26 Final Submission	Discussion	Chief Finance Officer	Enc.	12.30
<b>QUALITY</b>					
16.	Quality Committee Upward Reports: February and March 2025	Information	NED Chair	Enc.	12.45
17.	Patient & Carer Experience Committee Upward Report	Information	NED Chair	Enc.	12.55
<b>LUNCH (40 MINUTES)</b>					<b>13.05</b>

<b>PEOPLE</b>					
18.	People & EDI Committee Upward Report	Information	NED Chair	Enc.	13.45
<b>FINANCE, IM&amp;T &amp; PERFORMANCE</b>					
19.	Finance, Digital & Performance Committee Upward Report 19.1. Finance Report Month 11	Information	NED Chair	Enc.	13.55
20.	Audit and Risk Committee Upward Report 20.1 Board Assurance Framework	Information	NED Chair	Enc.	14.05
<b>CLOSING BUSINESS</b>					
21.	Any Other Business	Information	Chair	Verbal	14.15
22.	Date of Next Meeting: 8 April 2025 (Trust Board in Common with UHBW Trust Board)	Information	Chair	Verbal	-
23.	Exclusion of the Press and Public	Approval	Chair	Verbal	-
<b>END</b>					<b>14.20</b>

**BREAK BEFORE PRIVATE BOARD (10 minutes)**

**TRUST BOARD DECLARATIONS OF INTEREST**

Name	Role	Interest Declared
Ingrid Barker	Joint Chair	<ul style="list-style-type: none"> <li>• Governor, University of Gloucestershire</li> <li>• Member of the Faculty of TPC Health – a coaching company working predominantly in the NHS and Social Care (since January 2024)</li> <li>• Deputy Lieutenant of Gloucestershire</li> </ul>
Mr Kelvin Blake	Non-Executive Director	<ul style="list-style-type: none"> <li>• Non-Executive Director of BRISDOC.</li> <li>• Chair and Trustee of Second Step.</li> <li>• Trustee of the SS Great Britain Trust.</li> <li>• Trustee of the Robins Foundation.</li> <li>• Member of the Labour Party</li> <li>• Elected Member of Bristol City Council.</li> </ul>
Mr Richard Gaunt	Non-Executive Director	<ul style="list-style-type: none"> <li>• Non-Executive Director of Alliance Homes, social housing provider.</li> </ul>
Ms Kelly Macfarlane	Non-Executive Director	<ul style="list-style-type: none"> <li>• Sister is Centre Leader of Genesiscare Bristol (Private Oncology).</li> <li>• Sister works for Pioneer Medical Group, Bristol.</li> <li>• Managing Director, HWM-Water (a Halma manufacturing company).</li> <li>• Director, Radcom Technologies Limited (dormant company).</li> <li>• Director of ASL Holdings Limited (a Halma company – IoT solutions).</li> <li>• Director of Invenio Systems Limited (water loss consultancy).</li> <li>• Non-Exec Director of Advanced Electronics Limited (a Halma fire safety company).</li> </ul>
Professor Sarah Purdy	Non-Executive Director	<ul style="list-style-type: none"> <li>• Professor Emeritus, University of Bristol.</li> <li>• Fellow of the Royal College of General Practitioners.</li> <li>• Fellow of the Royal College of Physicians.</li> <li>• Trustee, Barts Charity.</li> <li>• Shareholder (more than 25% but less than 50%) Talking Health Limited.</li> </ul> <p>Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is:</p>

		<ul style="list-style-type: none"> <li>- Chair, Armada Topco Limited.</li> <li>- Director, Talking Health Ltd.</li> <li>- Chair, EHC Holdings Topco Limited.</li> </ul>
Dr Jane Khawaja	Non-Executive Director	<ul style="list-style-type: none"> <li>• Employee and Member of the Board of Trustees, University of Bristol.</li> <li>• Director of Gloucestershire Cricket Foundation.</li> <li>• Commissioner, Bristol Commission on Race Equality.</li> </ul>
Mr Shawn Smith	Non-Executive Director	<ul style="list-style-type: none"> <li>• Bluebells Consultancy Ltd (sole shareholder).</li> <li>• Governor of City of Bristol College.</li> <li>• Trustee of Frank Water.</li> <li>• Elim Housing Association (Board member).</li> </ul>
Maria Kane	Joint Chief Executive	<ul style="list-style-type: none"> <li>• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to Southmead Hospital Charity).</li> <li>• Visiting Professor to the University of the West of England (unremunerated).</li> <li>• Trustee of Help to Create Hope Charity.</li> </ul>
Mr Glyn Howells	Hospital Managing Director	<ul style="list-style-type: none"> <li>• Nothing to declare.</li> </ul>
Mr Tim Whittlestone	Chief Medical Officer	<ul style="list-style-type: none"> <li>• Director of Bristol Urology Associates Ltd: undertakes occasional private practice (Urology Specialty) at company office, outside of NBT contracted hours.</li> <li>• Chair of the Wales and West Acute Transport for Children Service (WATCH).</li> <li>• Vice Chair of the South-West Genomic Medicine Service Alliance Board.</li> <li>• Wife is an employee of the Trust.</li> <li>• Director of 3RO Ltd (providing medical advice to international NGOs etc).</li> </ul>

Name	Role	Interest Declared
Professor Steve Hams	Chief Nursing Officer	<ul style="list-style-type: none"> <li>• Visiting Professor, University of the West of England.</li> <li>• Director, Curhams Limited (dormant company).</li> <li>• Independent Trustee and Chair of the Infection Prevention Society.</li> <li>• Associate Non-Executive Director, Surrey Heartlands Integrated Care Board.</li> <li>• Husband is employed by Oxford University Hospitals NHS Foundation Trust.</li> <li>• Affiliate Member, Bristol and Avon St John Priory Group.</li> <li>• External Examiner – School of Nursing BPP University</li> </ul>
Mr Neil Darvill	Chief Digital Information Officer (to NBT and UHBW) (non-voting position)	<ul style="list-style-type: none"> <li>• Wife works as a senior manager for the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB).</li> <li>• Stepbrother is an employee of the Trust, working in the Cancer Services Team.</li> </ul>
Mr Peter Mitchell	Interim Chief People Officer (non-voting position)	<ul style="list-style-type: none"> <li>• Nothing to declare.</li> </ul>
Mr Nick Smith	Interim Chief Operating Officer	<ul style="list-style-type: none"> <li>• Nothing to declare.</li> </ul>
Elizabeth Poskitt	Interim Chief Financial Officer	<ul style="list-style-type: none"> <li>• Nothing to declare.</li> </ul>

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Volunteer Story		
<b>Report Author:</b>	Kathryn Tudor-Thomas, Volunteer Service Manager Emily Ayling, Head of Patient Experience Paul Cresswell, Director of Quality Governance		
<b>Report Sponsor:</b>	Steve Hams, Chief Nursing Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		X	X
	The purpose of this item is to provide insight into the volunteer experience of Volunteer Befriender, Stewart, who was previously a patient under the care of North Bristol NHS Trust in 2021.		
<b>Key Points to Note</b> ( <i>Including any previous decisions taken</i> )			
<ul style="list-style-type: none"> <li>Stewart's story provides insight into his motivations for becoming a Volunteer Befriender supporting patients within Neurosurgery and Neurology.</li> <li>Stewart highlights the challenging parts of the role, especially relating to meeting people who have the same illness he is experiencing.</li> <li>Stewart talks about rewarding aspects of volunteering, and how the role can support patients in a variety of ways.</li> <li>Stewart was influenced to volunteer by his experience within NBT as a patient and reflects how volunteering has helped his mental health, and what support he needs to volunteer.</li> <li>Stewart's story highlights the valuable insight NBT patients can bring to their volunteering role, offering support to patients using their own unique perspective.</li> </ul>			
<b>Strategic and Group Model Alignment</b>			
The item directly links to, and accompanies, the newly proposed Volunteer Services Strategic Plan 2025-2028 (agenda item 10). Our volunteers aim to provide an outstanding patient experience by providing a holistic approach to patient care. Our volunteer service supports our trust objective to be an anchor in our community, through connecting a diverse range of volunteers to roles throughout the hospital. Our strategic plan strives to embrace the opportunity to work more closely alongside University Hospital Bristol and Weston Foundation Trust (UHBW) Volunteer Services.			
<b>Risks and Opportunities</b>			
There are no risks identified from this story. There are opportunities to recognise the unique perspective of a volunteer who has had personal lived experience as a patient. Our Strategic Plan focuses on ways to recognise barriers people who are experiencing health inequalities face when considering volunteering. Our broader understanding will result in adaptations to our recruitment and management processes to expand our pool of volunteers.			
<b>Recommendation</b>			

<p>This report is for Discussion and Information.</p> <p>The Board is asked to discuss Stewart's story and reflect on the mutual impact volunteering brings to our patients and the volunteer alike. The Board is asked to note the existing time our team of volunteers dedicate to NBT.</p>	
<p><b>History of the paper (details of where paper has <u>previously</u> been received)</b></p>	
None	N/A
<b>Appendices:</b>	Appendix 1: Stewart's Volunteer Story



North Bristol  
NHS Trust

# Introduction

# Stewart's Story





NHS Cadets



Peer Support Volunteer



Patient Experience



Move Maker



Patient Befriender



Survey Volunteer

Volunteer

**DRAFT Minutes of the Public Trust Board meeting held on Thursday 30 January 2025 at 10.00am in Seminar Room 4, Learning and Research Building, Southmead Hospital and virtually via Microsoft Teams**

<b><u>Present (Board members):</u></b>			
Ingrid Barker Sarah Purdy Richard Gaunt Jane Khawaja Kelly Macfarlane Shawn Smith Kelvin Blake	Joint Trust Chair and Non-Executive Director (NED) Vice Chair and Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director	Maria Kane Glyn Howells Steve Curry  Neil Darvill Steve Hams Peter Mitchell Elizabeth Poskitt Tim Whittlestone	Joint Trust Chief Executive Hospital Managing Director Chief Operating Officer and Deputy Chief Executive Joint Chief Digital Information Officer Chief Nursing Officer Interim Chief People Officer Interim Chief Finance Officer Chief Medical Officer
<b><u>Also in attendance:</u></b>			
Elliot Nichols Xavier Bell	Director of Communications Director of Corporate Governance and Trust Secretary	Richard Gwinnell Eric Sanders	Deputy Trust Secretary ( <i>minutes</i> ) Director of Corporate Governance, University Hospitals Bristol & Weston NHS Foundation Trust (UHBW)
<b><u>Presenters:</u></b>			
Emily Ayling  Paul Cresswell	Head of Patient Experience ( <i>present for minute item TB/25/01/03</i> ) Director of Quality Governance ( <i>present for minute item TB/25/01/03</i> )	Ann O'Malley	Patient Access and Inclusion Lead ( <i>present for minute item TB/25/01/03</i> )

<b>TB/25/01/01</b>	<b>Welcomes and apologies for absence</b>	<b>ACTION</b>
	<p>Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol &amp; Weston NHS Foundation Trust (UHBW), welcomed everyone to the meeting. Ingrid also welcomed members of the public and staff who were observing the meeting. She reminded everyone that the meeting would be recorded, and the recording placed on the Trust's website for others to view, after the meeting. Everyone expected was present; there were no apologies.</p> <p>Ingrid also informed the Board that this was Steve Curry's last Board meeting, prior to his departure from NBT. Ingrid expressed the Board's appreciation for Steve's huge contribution to and major positive impact on patient care at NBT (with further speeches to be made at a later date).</p>	
<b>TB/25/01/02</b>	<b>Declarations of Interest</b>	
	No interests were declared in items on the agenda, nor any changes to the Trust Board register of interests currently published on the NBT website and annexed to the Board papers.	
<b>TB/25/01/03</b>	<b>Patient Story</b>	
	Paul Cresswell, Director of Quality Governance, introduced Ann O'Malley, whose role involved working to improve patient engagement, voluntary sector liaison and engagement with people from diverse backgrounds, helping the Trust achieve its aims of reducing health inequalities and delivering outstanding patient experience.	

Ann O'Malley, Patient Access and Inclusion Lead, displayed slides containing statistics and a video produced by Southern Brooks, including an interview with Diane, who was a member of the Gypsy Roma and Traveller community (GRT) living in South Gloucestershire. The Board heard (in summary) that:

- 44% of people in the UK openly expressed negative feelings towards Gypsies, Roma and Travellers
- 91% of 199 respondents had experienced discrimination and 77% had experienced hate speech or a hate crime
- there were 4,600 ethnic Romany Gypsies and Irish Travellers in Bristol, with approximately the same number of Eastern European Roma
- there were more than 250 GRT families living in South Gloucestershire (approximately 1,000 people)
- 74 out of 100 GP surgeries in England refused registration for GRT people; this meant GRT people could not get to see a doctor when they needed to, so their only option might be to go to a hospital when in need
- levels of domestic abuse among GRT people was nearly twice as high as in the wider population (65% compared to 33%)
- suicide rates among GRT people were 7 times higher than the rest of the UK population
- GRT people faced discrimination, racism, fear and mistrust
- if a GRT person was on a waiting list and relocated, they had to start again in another location (and go to the back of the list there)
- GRT people did not want to go to hospital; they knew they would face discrimination, experience false assumptions and find it very difficult to get the treatment they might need
- Diane's daughter had gone to hospital reluctantly after several days of extreme pain, but had faced discrimination and this had discouraged her further from going to hospital again
- GRT people only went to hospital if they were desperate for help
- life expectancy among GRT people was on average 15 years lower than the wider population
- GRT people wished to be treated as everyone else was
- there were too few sites in the UK for GRT people, so they had to move around more than most people; they therefore needed help from a doctor quickly, when they sought that help; not being added to a long waiting list
- most GRT people could not read or write and did not understand difficult words; they needed simple explanations of medical language.

*Richard Gaunt joined the meeting during the above presentation.*

Ann O'Malley also displayed and outlined slides containing information on the actions being taken now or planned for the future by NBT to help address these issues, including:

- working in close partnership with UHBW, councils, universities, Southern Brooks, Learning Partnership West (LPW) and other organisations
- GRT outreach work; building relations, trust and feedback mechanisms; giving GRT people a voice that they previously haven't had
- making every contact count (e.g. in the emergency department or in maternity); using every opportunity to engage with GRT people, wherever they presented themselves for treatment
- education/prevention: helping educate GRT people about health conditions such as Asthma
- delivering cultural awareness training for staff
- prevention, screening and reasonable adjustments; for example, going out to GRT communities, rather than expecting them to go to hospital for tests



	<ul style="list-style-type: none"> <li>• screening GRT people at a younger age for various conditions, recognising their lower life expectancy.</li> </ul> <p>The Board discussed the presentation and issues raised at length, with the following key points made or questions raised:</p> <ul style="list-style-type: none"> <li>• thanking Ann and everyone else involved for this vital work and insight</li> <li>• GRT people faced a great depth of inequality and discrimination</li> <li>• connections with housing associations may be useful; for example with Elim Housing Association, who worked with GRT community representatives</li> <li>• what the Integrated Care Board (ICB) was doing to help GRT people?</li> <li>• several years ago, there was a GP who specialised in work with GRT people; was this still the case?</li> <li>• there were many other marginalised communities who should also be helped, including people from black, Asian and other ethnic communities, working class people, disabled people and others</li> <li>• caring and compassion for everyone should be the aim; staff should be awarded for displaying the Trust's positive behaviours and values</li> <li>• the Board had made an anti-racism commitment; this work with GRT people was very welcome and more work was needed</li> <li>• whether more could be done in terms of lung health checks for example?</li> <li>• that any screening equipment could potentially be taken out of the hospital and into communities including GRT communities; the roll-out of Covid-19 vaccines on GRT sites had been very successful</li> <li>• it may be possible to replicate this with lung health checks and cancer screening for example; Tim Whittlestone undertook to hold discussions and explore options further after the meeting</li> <li>• whether links were made with the People Team in the context of staff showing compassion and the "Living our Values" initiative?</li> </ul> <p>Ann O'Malley replied to specific questions, that the position of the ICB was not well known, but there had been a successful ICB project involving Cardio checks at one GRT site; that any further contacts (with Elim Housing for example) would be welcome; and that discussions were ongoing with the People Team and LPW (including discussions about apprenticeships).</p> <p>Ingrid Barker thanked Ann, asked Ann to pass on the Board's thanks to Diane for her story and commented that there was clear commitment amongst the Board to make progress on this agenda, which could have a huge impact in the future.</p> <p><b>RESOLVED: the Board welcomed Diane's story and the work being done at NBT to better engage with members of the GRT community; the Board was committed to continue and develop this work.</b></p> <p><i>Emily Ayling, Paul Cresswell and Ann O'Malley left the meeting.</i></p>	
TB/25/01/04	<b>Questions from the Public</b>	
	<p>A public question had been submitted by Barbara Harris, a resident of Downend, Bristol. The question and answer were read aloud by Xavier Bell, Director of Corporate Governance and Trust Secretary, as follows:</p> <p><i>Question: I understand that it is the intention of the Board to move all mental health facilities from the Southmead Hospital site and locate them in new premises off Callington Road. When this has been accomplished, presumably the site will be cleared for further services? What services does the Board plan to implement on the cleared site, please?</i></p>	

	<p>Answer: <i>Avon and Wiltshire Partnership (AWP) provide most of the mental health services on the Southmead site. They are relocating some of their services to the Callington Road site and are happy to provide you with information about what is moving and when – their Associate Director of Communications is Gary Morgan, who is contactable on <a href="mailto:Gary.morgan7@nhs.net">Gary.morgan7@nhs.net</a>.</i></p> <p><i>North Bristol NHS Trust (NBT) is liaising with AWP around their plans for the Southmead site as we currently rent some of the space owned by AWP and are interested in finding out more about how we can potentially use the estate in the medium to longer term. We have been advised that AWP are looking to re-purpose the space once the existing services have been moved. This will enable AWP to complete critical refurbishment works to other parts of its estate as part of their lifecycle plans. To develop the site more significantly e.g. clearing and rebuilding, would require capital funds that are not available to either Trust at this time.</i></p>	
<b>TB/25/01/05</b>	<b>Minutes of the previous Public Trust Board Meeting</b>	
	<b>RESOLVED: the minutes of the Public Trust Board meeting held on 28 November 2024 were approved as a correct record of proceedings.</b>	
<b>TB/25/01/06</b>	<b>Action Log</b>	
	<p>Xavier Bell presented the action log and provided the following updates:</p> <ul style="list-style-type: none"> <li>Action 94 would be closed when the report on the violence and aggression (including sexual safety at work) audit had been submitted to the People and EDI Committee</li> <li>Action 95 could now be closed, as the Board Insight Visits (BIVs) feedback forms had recently been reviewed and would be circulated to Non-Executive Directors (NEDs) in the near future for their comments, and staff hosting BIVs would be informed that NEDs may wish to speak to patients and staff during future visits.</li> </ul> <p><b>RESOLVED: the Action Log updates were noted and action 95 was closed.</b></p>	
<b>TB/25/01/07</b>	<b>Matters arising from the previous meeting</b>	
	No matters were raised.	
<b>TB/25/01/08</b>	<b>Joint Chair's Report</b>	
	<p>Ingrid Barker presented her report, highlighting:</p> <ul style="list-style-type: none"> <li>the recent change of Lead Governor at UHBW, with Ben Argo taking over from Mo Philips</li> <li>her continuing visits and meetings at UHBW and NBT, some undertaken jointly with the NBT Vice-Chair, Sarah Purdy</li> <li>the importance of Executives from UHBW and NBT meeting each other and working closely in the context of the emerging Hospital Group</li> <li>the range of groups and meetings she had attended in the context of the emerging Hospital Group</li> <li>her recent meetings with partner organisations and representatives including local MPs</li> <li>her planned involvement in reciprocal joint visits to other Trusts with other Trust Chairs (including Sirona) starting soon, to promote mutual understanding and continue building relations</li> <li>her attendance at national conferences and events, including the recent NHS Providers National Conference, which was very useful.</li> </ul>	

	<b>RESOLVED: the Board noted the activities and key developments reported by the Joint Chair.</b>	
<b>TB/25/01/09</b>	<b>Joint Chief Executive's Report</b>	
	<p>Maria Kane presented her report, commenting specifically on:</p> <ul style="list-style-type: none"> <li>• the expectation that planning guidance would be received soon</li> <li>• the Reforming Elective Care for Patients requirements, including 65% of patients waiting less than 18 weeks for elective care and the requirement for every Trust to deliver a minimum 5% improvement by March 2026</li> <li>• ongoing work and good progress towards meeting the existing targets</li> <li>• the general environment of austerity and need to plan accordingly</li> <li>• the consultation on future regulation of NHS managers, the deadline for comments on which was 18 February</li> <li>• ongoing consultation on the NHS 10-year plan, to find out what partners and the public want to see in the plan; with an event planned at the BAWA Club today and a regional strategic partnership event planned for 26 February</li> <li>• meetings she had attended and had planned, including with the Leader of Bristol City Council and with Darren Jones MP</li> <li>• her involvement in the Bristol Reducing Serious Youth Violence Board and the worrying increase in youth violence nationally</li> <li>• the charging of three young people for their part in the death of Eddie King in Bristol last year, with a trial expected in the near future</li> <li>• ongoing operational pressures, which were managed well by NBT staff but continued, with larger than usual numbers of patients presenting at the front door, infections and flu still high, and the number of patients with no criteria to reside still high; she commended staff for their hard work</li> <li>• the recent announcement that the University of Bristol had been awarded the highest score for research quality in clinical subjects as part of the Times Higher Education World Rankings in Medicine and Health; this reflected that Bristol and NBT were leading centres of global medical research.</li> </ul> <p>Glyn Howells, Hospital Managing Director also updated the Board on:</p> <ul style="list-style-type: none"> <li>• the first Town Hall meeting which had been held recently (with more planned every six weeks); over 600 staff had attended the Teams call and many pertinent questions were asked</li> <li>• meetings he was holding on a regular basis with clinical directors, to explore key issues and ask searching questions in a new way</li> <li>• delays to the completion of the Elective Centre; discussions with Darwin Group were continuing, as was work on the implications</li> </ul> <p>Ingrid congratulated everyone involved for the recent Times award and their excellent work.</p> <p><b>RESOLVED: the Board noted the Chief Executive's report.</b></p>	
<b>TB/25/01/10</b>	<b>Madeline (Maddy) Lawrence Improvement Plan</b>	
	<p>Tim Whittlestone, Chief Medical Officer, presented the report, which provided an update on the learning and improvement which had taken place since Maddy's sad death due to unrecognised deterioration and sepsis at NBT in March 2022. Tim displayed a video of an extract of Maddy's Training, which was being rolled out for all clinical staff across the Trust and which was made in conjunction with Maddy's parents, who were now part of a national campaign to improve the recognition and treatment of patients with deteriorating conditions.</p> <p>Tim highlighted and explained (and responded to questions):</p>	

- the history of Maddy's case and the subsequent investigations, inquest, media and Care Quality Commission (CQC) involvement
- the extensive work which had taken place since then to ensure a case like Maddy's could not happen at NBT again
- the key steps and components of this work, including updating clinical policies and guidelines, more active monitoring of patients including using the NEWS2 score early warning system, extensive staff training and improved recognition of deterioration, as well as escalation and response
- the importance of recording and responding quickly and appropriately to observations of patients' conditions taken on wards
- the launch of the new Acute Response Team planned for February 2025; this would enhance the existing night service
- improvements in governance including the Deteriorating Patient Group and appointment of a clinical lead for deteriorating patients
- the key messages behind the training: that every patient was someone's son, daughter and so on; that behind all observations there was a person; and the serious consequences of not following procedures correctly
- the importance of the NEWS2 scoring system, recognising deterioration and responding quickly and appropriately
- the introduction at NBT of Martha's Law, which required that every patient was asked daily, how they felt and whether they felt better or worse than the day before, and gave patients and carers the chance to contact someone if they were not happy with the care they were receiving
- Martha's Law was a mandated approach; every patient had to be asked the relevant questions, their response had to be recorded and a response that they felt worse (than the day before) had to trigger a clear response
- Martha's Law had already been piloted in ten clinical areas and would be rolled out Trust-wide in March 2025
- that NBT had recently been "signed off" as compliant by the CQC
- staff now had a very different way of undertaking observations and screens in every ward showed relevant patient data, with changes in NEWS score triggering human intervention much more effectively
- 51% of staff had received Maddy's Training in four months; this level of take-up was unprecedented
- that NBT was working with NHS England in the hope that Maddy's Training would become a national training tool
- that everyone at NBT knew the name Maddy Lawrence; there had been a real and tangible cultural shift.

Board members reiterated their sadness about Maddy's death and welcomed the progress made since then. The following key points arose during discussion:

- everyone at NBT was clearly committed to these improvements
- the work undertaken to put new processes, systems and knowledge in place since Maddy died had been extensive and impressive; staff were thanked for their hard work
- concerns had been raised at UHBW about recording of data in Vitals; was this a problem of which NBT should be aware?
- no concerns about data software were known of, but discussions would be held (by Tim) with colleagues at NBT and UHBW
- automated decision support systems were one element of getting it right, but more important was human behaviour
- the most important question was: how did the patient look and feel?
- NBT patients were significantly safer as a result of this work; a great deal had changed and NEWS2 was a crucial component of that
- UHBW had some issues with paediatric scoring software, not all software
- NBT staff had shown a great deal of willingness to learn and change, and no defensiveness; this was a cultural shift.



	<p>Ingrid Barker reiterated the Board's sadness at Maddy's death and commented on the debt of gratitude owed to Maddy's parents. She stated the Board took a great deal of assurance from the evidence presented of the significant changes for the better at NBT since Maddy's death and thanked Tim and other staff involved.</p> <p><b>RESOLVED: the Board noted the report, noted the improvements made and noted the delivery of the improvement plan.</b></p>	
	<i>The Board adjourned at this point for a brief comfort break.</i>	
<b>TB/25/01/11</b>	<b>Quality Committee Upward Report and Maternity Incentive Scheme Year 6</b>	
	<p>Sarah Purdy, Vice-Chair of the Trust Board and Chair of the Quality Committee, presented the report, highlighting:</p> <ul style="list-style-type: none"> <li>• the Trust's successful compliance with all ten of the required safety actions and sub-actions of the Maternity Incentive Scheme (MIS)</li> <li>• that the Committee had decided to escalate trust-level risk 1704 to the Board for discussion; risk 1704 being that Stroke patients do not receive the optimum care in line with national guidance, due to poor flow of stroke patients out of the acute hospital and into ongoing rehabilitation units, resulting in Stroke no criteria to reside (whilst recognising that clinical teams were compensating for this through managing Stroke patients in non-Stroke beds).</li> </ul> <p>Ingrid Barker referred to the significant problem of no criteria to reside (NC2R) across the whole of Bristol, not just at NBT, with on average 23% of patients (and a few months ago, as high as 40% of patients) having no criteria to reside in hospital. She asked for more detail of what "sub-optimal care" meant in practice and whether Stroke patients were safe at NBT.</p> <p>Steve Curry, Chief Operating Officer and Deputy Chief Executive explained that Stroke patients were being managed well, and safely, in the 40 beds available at NBT, which should ideally be 70 beds; patients were receiving good clinical care at NBT and safety was good; however the overall standard of care for Stroke patients was not ideal, due to the lack of rehabilitation beds in the wider system. NBT was working closely with system partners.</p> <p>Comments were made and questions were asked by other Board members in brief:</p> <ul style="list-style-type: none"> <li>• that the rate of NC2R at NBT was currently around 22%</li> <li>• Sirona had a rate of around 50%; they were also full</li> <li>• that the issue was outcomes for people who had suffered a stroke</li> <li>• what was the impact on patients of delayed after-care?</li> <li>• how the situation could be improved with partners and whether the right discussions were being held?</li> <li>• that the consequence of the lack of specialist rehabilitation units was that patients did not receive the best after-surgery therapy and that patients had to stay in hospital longer than necessary; this could result in harm to patients as a result of falls, pressure ulcers and so on</li> <li>• all parts of the system had a collective responsibility for patient care</li> <li>• the issue was lack of funding for social care</li> <li>• whether the issue out-of-hospital was a lack of beds or lack of staff?</li> <li>• NBT was the largest acute Stroke hospital in the country and demand was not likely to shrink; perhaps NBT needed to increase its capacity.</li> </ul> <p>Steve Curry responded, explaining that the SNAP data showed that NBT had been A-rated for Stroke, but increasingly, patients were not [located] where they ideally</p>	

needed to be. The current rating was C, with a route back to B, but A more difficult to achieve. If flow could not be resolved due to lack of capacity in the wider system, NBT would have to look at increasing its capacity, to meet the demand of the number of people suffering strokes (“right-sizing”), including providing rehabilitation at NBT. The issue was not about treating patients who had suffered a stroke, it was about where they recovered, and the extent and speed of their recovery. The SNAP data provided clear clinical evidence of the impact of the challenges, and this was being used to leverage influence where possible. Every bed available was being used to its full capacity and extensive communication with system partners was taking place to alleviate the situation as quickly and effectively as possible.

Ingrid referred to the need for more conversations at Integrated Care Board (ICB) level, as this was clearly a system-wide issue, and looked forward to updates. Maria Kane commented that the problem extended beyond the ICB; this was about discussions taking place about funding, at the regional level and with SpecCom.

Steve Hams, Chief Nursing Officer, summarised the Maternity Incentive Scheme (MIS) Year 6 report briefly. He commented that NBT was compliant across all ten of the safety actions and sub-actions, and that, where 100% compliance had not been achieved yet (e.g. in terms of staffing numbers), action plans were in place. With these action plans in place, the MIS report could be signed off and NBT was compliant. He thanked and commended the staff of Maternity Services and the Committee Chair and Non-Executive Director Champion for their extensive work.

**RESOLVED that:**

- **the Quality Committee report and its assurance on behalf of the Board be noted**
- **that the Stroke update be noted**
- **that the following statements be approved and agreed and that the Trust Board approves the declaration of compliance with the MIS Year 6 requirements in light of the supporting evidence:**
  - An audit of 6 months of activity for meeting the Royal College of Obstetricians and Gynaecologists (RCOG) criteria of employing short term locums was undertaken from February to August 2024. At least one of the RCOG criteria requirements were met by all employed short term locums.
  - Compliance for consultant attendance for clinical situations listed in the RCOG workforce document is monitored, there have been no episodes of non-attendance throughout the MIS year 6 reporting period.
  - The neonatal medical workforce is in line with the British Association of Perinatal Medicine (BAPM) national standards of medical staffing.
  - The neonatal unit does not currently meet the BAPM national standards of nursing staff. The action plan (Appendix 3) to be received and signed off by Trust Board to demonstrate working towards a position of compliance with BAPM standards for neonatal nursing. Progress can be evidenced through increased number of Qualified in Speciality (QIS) trained staff and a reduction in the neonatal nursing workforce vacancy rate.
  - Board Safety Champions have met with the Perinatal Leadership team monthly to discuss any support required from the Trust and implementation of this.
  - The Trust Board have sight of Healthcare Safety Investigation Branch/Maternity and Newborn Safety Investigations (HSIB/MNSI) incidents and the number of cases reported to HSIB/MNSI and NHS Resolution (NHSR), families have received information on the role of HSIB/MNSI and the NHSR Early Notification Scheme and evidence of compliance with the statutory duty of candour.

<p><b>TB/25/01/12</b></p>	<p><b>Patient and Carer Experience Committee Upward Report</b></p> <p>Kelvin Blake, Non-Executive Director and Chair of the Patient and Carer Experience Committee presented the Committee's Upward Report. Kelvin highlighted:</p> <ul style="list-style-type: none"> <li>• the extent and importance of the work of the Committee and its sub-groups</li> <li>• the importance of continuing that work in the new Group structures</li> <li>• the excellent work of all the teams involved</li> <li>• that NBT was outperforming and leading the way compared to other Trusts in many areas, including End of Life Care, Patient Conversations and the Learning Disabilities Mortality Review</li> <li>• excellent Urgent and Emergency Care patient survey results, despite the massive pressures on the service.</li> </ul> <p>Steve Hams also commended the teams for their hard work and successes, referring to Friends and Family Test (FFT) feedback and very good patient survey feedback, compared to many other Trusts.</p> <p>Ingrid Barker reiterated the need to maintain NBT's key focus on patient voice and referred to meetings planned for March with the Patient and Carer Partnership Group, and with Governors at UHBW, to discuss what engagement mechanisms would work best for patients and carers in the new Hospital Group structure. She thanked Kelvin and the Committee for all their work.</p> <p><b>RESOLVED: the Board noted the Patient and Carer Experience Committee report and its assurance on behalf of the Board.</b></p>	
<p><b>TB/25/01/13</b></p>	<p><b>People and EDI Committee Upward Report and Long-term Workforce Plan</b></p> <p>Kelvin Blake, Non-Executive Director and Chair of the People and Equality, Diversity and Inclusion (EDI) Committee presented the Committee Upward Report. Kelvin highlighted:</p> <ul style="list-style-type: none"> <li>• the recommendation to stand down 6-monthly refreshes of the Carnall Farrar long-term workforce planning model and reports to the Board, given the extensive other work in progress, including Hospital Group work</li> <li>• the early staff survey results and positive messages it entailed</li> <li>• ongoing work on Living our Values and equality, diversity and inclusion</li> <li>• ongoing anti-racism training, with feedback indicating its effectiveness.</li> </ul> <p>Peter Mitchell, Interim Chief People Officer added in brief:</p> <ul style="list-style-type: none"> <li>• that detailed workforce data was contained in the integrated performance report, later on the agenda</li> <li>• NBT was on a continuing and positive cultural journey</li> <li>• that change was recommended to the regularity and reporting lines of work on long-term workforce planning (LTWP); planning itself was continuing apace, but not using the Carnall Farrar (CF) model</li> <li>• NBT staff were now working very closely with colleagues at UHBW and the ICB on LTWP; their approach to workforce planning was different, as was the approach recommended by NHS England</li> <li>• the CF model had been very useful and valuable at the time it was initiated but circumstances had changed; there was no barrier to using CF again in future if NBT so chose.</li> </ul> <p>Maria Kane emphasised that a great deal of work had been done on workforce planning with the help of the CF model, but circumstances had changed and work</p>	

	<p>now needed to move on, in the context of the Hospital Group. The advice received from CF on future-proofing the workforce had been good advice.</p> <p>Kelvin concurred, the CF model had been very useful and the learning from it would not be lost; however, the workforce gaps which existed a year ago had been filled and time was needed now to pause, reflect and move on to other challenges.</p> <p><b>RESOLVED: the Board:</b></p> <ol style="list-style-type: none"> <li>(1) noted the People and EDI Committee report and its assurance on behalf of the Board and</li> <li>(2) approved the standing down of the use of the CF model and six-monthly updates to the Board</li> <li>(3) approved the remainder of the work proposed in the report, including annual updates on workforce planning being submitted to the People and EDI Committee.</li> </ol>	
TB/25/01/14	<b>Integrated Performance Report (IPR)</b>	
	<p><u>Performance Scorecard and Responsiveness</u></p> <p>Steve Curry outlined this section of the report, highlighting:</p> <ul style="list-style-type: none"> <li>• generally positive performance overall across the four domains (urgent care, elective care, diagnostics and cancer waiting time standards) with particular challenges in Urgent and Emergency Care, including meeting the 4-hour performance target, caused by a combination of increasing demand and reduced patient flow out of hospital</li> <li>• consistent improvement in Referral to Treatment (RTT) timescales</li> <li>• that the Trust was successful in delivering its 65-week RTT commitments 18 months earlier than the national requirement and now aimed to reduce 52-week wait breaches to less than 1% by the end of this year; this was significantly in advance of national targets</li> <li>• the national targets were changing, from looking at the longest waits, to looking at the % of people waiting longest; NBT was already ahead on this and aiming to improve by 5% this year</li> <li>• good performance against cancer waiting times, with NBT compliant against the 28-day and 62-day FDS (Faster Diagnosis Standard); sustaining good performance</li> <li>• further excellent results in Diagnostics, with NBT ahead of the national target (no more than 5% waiting more than six weeks); NBT had fewer than 1% waiting that long</li> <li>• surges in demand in December and January particularly causing further demand pressures as a result of flu and Norovirus</li> <li>• considerable work ongoing to reduce ambulance handover delays, increase bed availability with partner organisations and maximise the use of existing bed capacity</li> <li>• his thanks to all the staff involved for their continuing hard work</li> <li>• a proposal to work on a step-change improvement programme in future.</li> </ul> <p><u>Quality, Safety and Effectiveness</u></p> <p>Steve Hams highlighted:</p> <ul style="list-style-type: none"> <li>• Perinatal Quality Surveillance Metric (PQSM) data, which was shared with UHBW, which had to measure the same metrics</li> <li>• an exponential rise in the rate of C-sections in recent years and increasing expectations for the future</li> </ul>	

- the ambition to achieve 70% Qualified in Specialty (QIS) among the neonatal staffing workforce
- a worrying rise in C.diff infection rates; remaining lower than the UK and south-west averages but nevertheless an area of high focus
- a slight rise in pressure injuries, broadly in line with national rates and not abnormal for the time of year, but likely to increase, with high numbers of people with no criteria to reside.

Tim Whittlestone highlighted:

- sustained improvement in the number of medication errors, albeit with three moderate harm incidents in the latest reporting period and one patient allergy to antibiotics incident
- significant effort focused on minimising medication errors, including the planned roll-out in the next few months of electronic prescribing
- the positive impact of electronic prescribing on VTE risk assessments
- a positive patient safety picture overall.

### Finance

Elizabeth Poskitt, Interim Chief Finance Officer highlighted (or answered questions):

- a small financial plan surplus in December of approximately £0.1 million and continuing stabilisation
- the continuing stabilisation of agency/Bank spend
- the continuation of expenditure controls introduced in August, through to March, and the significant efforts of everyone involved
- the current year-to-date £6 million deficit against a planned £2.4m deficit, resulting in a year-to-date adverse variance of £3.6m
- £16.4m Cost Improvement Plan (CIP) savings completed at month 9, with £33m in implementation and planning and £7m in pipeline
- the cash position, £33.4m at the end of December
- significant capital spend plans for the remainder of the financial year, principally relating to the Elective Centre
- underspends on fire integrity would be carried forward into next year if not spent this year; plans were in place to undertake works and reduce risks but the timing was not always within NBT's control.

Elizabeth replied to detailed questions about CIP delivery and income capture.

Glyn Howells, Hospital Managing Director, stated that many Trusts would be envious of NBT's financial position. He reminded the Board of the recent Peer Review, which praised NBT's financial ownership at Board level. He thanked NED and Executive colleagues for their collective effort on the Trust's finances.

Ingrid recognised the huge achievements made and progress towards breakeven, thanking everyone involved.

### Well led/workforce

Peter Mitchell highlighted:

- positive People metrics in almost every area
- turnover, which had reduced in most areas and recently plateaued
- that work had recently shifted from healthcare support workover turnover to admin and clerical turnover rates, which had recently increased and were the subject of targeted action

	<ul style="list-style-type: none"> <li>• work focused on the disparity ratio action plan and other commitment to the community targets</li> <li>• further reductions in agency and Bank spend, on track to meet targets</li> <li>• the sickness absence rate, just off target (4.4%) at 4.6%</li> <li>• increasing vacancy rates, but expected in light of the vacancy controls introduced last Autumn due to the Trust's financial constraints</li> <li>• statutory and mandatory training rates achieved, above targets</li> <li>• positive People news, despite significant operational and financial pressures affecting the whole Trust.</li> </ul> <p><u>Patient Experience</u>: report taken as read. Steve Hams replied to a question from Maria Kane, that dipped performance against complaints response targets reflected workforce issues in ASCR but were predicted to improve.</p> <p><u>Regulatory</u>: report taken as read.</p> <p><i>Maria Kane, Glyn Howells, Elizabeth Poskitt and Kelvin Blake left the meeting.</i></p> <p><u>Research and Innovation</u></p> <p>Tim Whittlestone highlighted:</p> <ul style="list-style-type: none"> <li>• 84 new studies currently in place (against a target of 90 for the whole year), benefitting from a number of recent grants</li> <li>• his thanks to individuals, families and organisations who gave donations to Southmead Hospital Charity, which enabled funding of around £0.1m for small and medium sized medical research studies based at NBT (e.g. into dementia, obstetrics and the effectiveness of intensive care).</li> </ul> <p><b>RESOLVED: the Board noted the Integrated Performance Report and approved the regulatory compliance statements.</b></p>	
TB/25/01/15	<b>Emergency Preparedness, Resilience and Response (EPRR) Annual Report</b>	
	<p>Steve Curry presented the report, highlighting that NBT was a Category 1 Responder under the Civil Contingencies Act 2004 and, against 47 NHS Core Standards for EPRR, NBT was fully compliant (100%) with its responsibilities.</p> <p><b>RESOLVED: the Board noted the report and the Trust's full compliance.</b></p>	
TB/25/01/16	<b>Finance, Digital &amp; Performance Committee Upward Report</b>	
	<p>Richard Gaunt, Non-Executive Director and Chair of the Finance, Digital and Performance Committee, presented the report, highlighting:</p> <ul style="list-style-type: none"> <li>• the notable improvements in the financial position of the Trust over the last 18 months</li> <li>• a thorough assurance report on Digital received by the Committee, including the Backup risk being addressed by the end of March</li> <li>• the Committee's focus on the longest-standing risks, and thoughts emerging around how the Trust needed to live with some risks.</li> </ul> <p><i>Kelvin Blake returned to the meeting during the above presentation.</i></p> <p>Xavier Bell commented that a report on longest-standing risks would also be submitted to the Quality Committee in the near future.</p> <p><i>Steve Curry left the meeting.</i></p>	

	<b>RESOLVED: the Board noted the Finance, Digital and Performance Committee report and its assurance on behalf of the Board, and noted the month 9 finance report.</b>	
<b>TB/25/01/17</b>	<b>Any Other Business</b>	
	No other business was raised.	
<b>TB/25/01/18</b>	<b>Date of Next Meeting</b>	
	The next Board meeting in public was scheduled to take place on Thursday 27 March 2025, at 10am. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.	
<b>TB/25/01/19</b>	<b>Exclusion of the Press and Public</b>	
	<b>The Board RESOLVED:</b> that representatives of the press and other members of the public be excluded from the Trust Board meeting, having regard to the confidential nature of the business to be transacted at the Private Board meeting later in the day, publicity on which would be prejudicial to other public interest (section (2) Public Bodies (Admission to Meetings) Act 1960).	

The meeting ended at 12.45pm.

Trust Board Public ACTION LOG										
Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/ RAG	Info/ Update	Date action was closed/ updated
26/9/24	People & EDI Committee Upward Report	TB/24/09/15	94	That more data be presented to the People & EDI Committee on violence and aggression issues, including sexual safety at work	Peter Mitchell	Not specified	No	Closed	March 25 update: Audit underway and report scheduled to come to People & EDI Committee following completion by end of April 2025. Work on violence and aggression and sexual safety at work is now being led by the People Directorate with a structured plan and associated governance through the People Oversight Group. Updates/assurance being provided to the Board through the People & EDI Committee. This will be a continued priority following 2024 staff survey results. Action closed as oversight by People and EDI Committee is in place.	21/03/2025



<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Joint Chair's Report		
<b>Report Author:</b>	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
<b>Report Sponsor:</b>	Ingrid Barker, Joint Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
	To inform the Board of key items of interest to the Trust Board, including relevant activities of the Joint Chair during the period since the last Joint Chair's report, engagement with System partners and regulators and the Joint Chair's visits and events.		
<b>Key Points to Note</b> <i>(Including any previous decisions taken)</i>			
The Joint Chair reports to every Public Board meeting with updates relevant to the period in question.			
<b>Strategic and Group Model Alignment</b>			
The Joint Chair's report identifies her activities, along with key developments at the Trust and further afield, including those of a strategic nature.			
<b>Risks and Opportunities</b>			
Not applicable			
<b>Recommendation</b>			
This report is for discussion and information. The Board is asked to note the activities and key developments detailed by the Joint Chair.			
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>			
Not applicable		N/A	
<b>Appendices:</b>	N/A		

## 1. Purpose

The report sets out information on key items of interest to the Trust Board, including the Joint Chair's attendance at events and visits as well as details of the Joint Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

## 2. Background

The Trust Board receives a report from the Joint Chair to each meeting of the Board, detailing relevant engagements she has undertaken and important changes or issues affecting UHBW (and NBT) and the external environment during the preceding months.

### 3. **Connecting with our Trust Colleagues at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)**

The Joint Chair undertook a variety of visits and meetings during January and February 2025, including:

- Monthly meetings with Non-Executive Directors (NEDs)
- Monthly meetings with Vice-Chair
- Introductory meeting with David Wynick, Chair, Paul Kearney, CEO, and Katie Walker, CEO Designate, Bristol and Weston Hospital Charity
- Visit to Medical Wards with Hayley Long, Divisional Director of Nursing, Medicine
- Reciprocal Tour with Non-Executive Directors from both Trusts to Weston  
Locations included in the visit: Emergency Department/Same Day Emergency Care, two Care of the Elderly wards, two Surgical wards, Seashore, Ashcombe and Older Persons Assessment Unit
- Meeting with Lead Governor, Ben Argo
- Attended a Health Equity Delivery Group
- Visited Weston Community Diagnostic Centre
- Visit to a number of areas in the Children's Hospital, including the emergency department, intensive care unit and Lighthouse Ward
- Visit to the adult emergency unit, Acute Medical Unit (AMU) and Same Day Emergency Care Unit (SDEC)
- Met with Sustainability Team, hosted by Ned Maynard, Head of Sustainability

### 4. **Connecting with our Trust Colleagues at North Bristol NHS Trust (NBT)**

The Joint Chair undertook a variety of visits and meetings during November and December 2024, including:

- Alongside our Joint Chief Executive Officer, hosted a visit by Her Royal Highness, The Princess Royal to Southmead Hospital. It was an honour to accompany Her Royal Highness, during her recent visit where she reconnected with some of the staff who provided her care following an incident at the Gatcombe Park estate in June 2024. During her visit, Her Royal Highness had the opportunity to meet with doctors, nurses and allied health professionals who were directly involved in her treatment, recovery and discharge. The visit also provided a valuable moment to showcase the exceptional dedication of our clinical teams.
- Monthly meetings with Non-Executive Directors (NEDs)
- Monthly meetings with Vice-Chair
- Visit to Mortuary
- Introductory meeting with Fiona King, new JUC Chair
- Hosted a visit from Paul Miller, Chair, Avon and Wiltshire Mental Health Partnership NHS Trust. The areas visited included the Emergency Department, Mental Health Liaison Team at Donal Early House and S136 suite and Mother and Baby Unit, New Horizon
- Met with the Patient and Carer Partnership Group
- Visit to Elgar Ward

## 5. Communications

The Communications teams of both Trusts have been very helpful in making the above visits more visible to all colleagues and to UHBW Governors. For UHBW this has been through its platform Viva Connect and a newsletter to Governors. I would like to thank both teams for their support in this. For NBT this has been through its weekly staff newsletter, NBT News and intranet platform, LINK.

## 6. Group Development

The development of the group model is continuing at pace, focusing on finalising the group benefits realisation case, governance arrangements, and an operating model and accountability framework to facilitate joined up services for our patients and service users. This work is being driven through the work of a number of key groups including:

- Fortnightly Group Design Futures Working Group
- Joint Executive Group meetings
- Teneo Governance Working Group
- UHBW and NBT Board to Board workshops and development sessions
- Remuneration committees held in common
- Monthly joint NED meetings.

Two meetings were held with UHBW Governors in February 2025 to discuss Group governance, the draft benefit realisation case and the operation model. The Boards of UHBW and NBT also met formally together “in common” for the first time in February 2025 (in private session) and will begin meeting in this way in public from April 2025.

On 26 February, leaders from North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust, met with local partners to explore opportunities for collaboration as our Trusts move towards forming a Hospital Group. Bringing together dedicated healthcare professionals, partners and community leaders, the discussion was an invaluable opportunity to align our collective efforts in improving health and well-being across our region. Sincere thanks to all who contributed their insights and expertise to this important conversation.

## 7. Connecting with our Partners

The Joint Chair undertook introductory and follow-up meetings with a number of partners during January and February 2025 as follows:

- Alongside our Joint CEO, hosted a visit by Rt Hon Darren Jones, Chief Secretary to the Treasury to the Community Diagnostic Centre at Cribbs Causeway
- Introductory meeting with Paul Miller, Chair, Avon and Wiltshire Mental Health Partnership NHS Trust
- Attendance at the fortnightly City Partners Conference Call
- Attendance at the BNSSG ICP Board meeting
- Alongside our Joint CEO and UHBW Managing Director, met the CEO of Maggie's Centre to discuss plans for a centre for Bristol to support people undergoing a cancer journey

- Meeting with Kerry McCarthy, MP Bristol East
- Meeting with Maggie Tyrrell and Ian Boulton, Leaders of South Gloucestershire Council
- Introductory meeting with Stephen Peacock, Leader from the West of England Combined Authority
- BNSSG Chairs Reference Group, chaired by Jeff Farrar
- NHS Providers farewell event for Sir Ron Kerr, stepping down from his role as NHS Provides Chair
- Meeting with Matt Lenny, Director of Healthy and Sustainable Communities, including Director of Public Health, North Somerset Council
- Visit to For All Healthy Living Centre in Weston with Mark Graham, Chief Executive Officer
- Meeting with Mike Bell, Leader of North Somerset Council
- Meeting with Evelyn Welch, Vice-Chancellor and President, University of Bristol
- Meeting with Steve West, Vice-Chancellor, President and CEO, University West of England
- Visit by Dan Norris, in his capacity as WECA Metro Mayor to mark NBT and UHBW joining WECA's Good Employment Charter

## 8. National and Regional Engagement

The Joint Chair has also attended:

- The monthly National NHS Confederation Chairs' Group.
- Regular one to one 'touch points' with Elizabeth O'Mahony, NHSE South West Regional Director
- Attended a Good Governance Institute seminar on 'The White Paper on Local Government Reform'.
- Meetings with fellow Trust Chairs to share learning on the development of groups, Mehboob Khan from Barking, Havering and Redbridge (Barts Hospital Collaborative), Charles Alexander (Guys and St Thomas's), Andrew Moore (Leicester and Northampton Group) and Professor Derek Bell (Teeside Group)
- Alongside Becca Dunn, met with Professor Alf Collins of TPC Health, former NHSE national lead for Personalisation, to discuss the Trust's approach to 'What Matters to You?'
- We were delighted to welcome the Prime Minister, Sir Keir Starmer, to the Cribbs Causeway Community Diagnostic Centre. His visit offered a firsthand look at how we are delivering on our commitment to improve healthcare access. Our Community Diagnostic Centres (at Cribbs and Weston) play a crucial role in addressing health inequalities and this visit was a testament to the impact of collaborative efforts in enhancing patient care.
- National Chair and Chief Executive meeting

## 9. Vice-Chairs Report

The Vice-Chair undertook a variety of visits and meetings during January and February 2025, including:

- Fortnightly Group Design Futures Working Group
- UHBW and NBT Board to Board workshops and development sessions
- Remuneration Committee held in common

- Monthly joint Non-Executive Director meetings
- Monthly Quality Committee
- Attended an NBT/UHBW Hospital Group Strategic Partnership Event
- Visit to Volunteers Team
- Board Insight Visit to Ward 6B with Peter Mitchell, Chief People Officer
- Board Insight Visit to Ward 31b
- Met with Sue Bourne and Safeguarding Team
- Attended a Schwartz Round session
- FTSU Visit with Hilary Sawyer
- Met with Chriss Thirlwell, Head of Bristol Medical School, University of Bristol
- Attended an introduction/overview Group Mortality Improvement Programme meeting
- Attended a meeting on organ donation and transplantation strategy
- An NHS Providers Non-Executive Director Network
- Attended a Joint Non-Executive visit to Weston Hospital
- Chaired Consultant Interview panels for a Consultant Histopathologist and Hepatopathology and a Consultant Diagnostic Neuro-Radiologist
- Attendance at Patient and Carer Partnership Board

## **10. Summary and Recommendations**

The Trust Board is asked to note the content of this report.

<b>Report To:</b>	Trust Board Public Meeting		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Joint Chief Executive Report		
<b>Report Author:</b>	Suzanne Priest, Executive Co-ordinators		
<b>Report Sponsor:</b>	Maria Kane, Joint Chief Executive		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
			<b>X</b>
	The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.		
<b>Key Points to Note</b> <i>(Including any previous decisions taken)</i>			
<p>The report seeks to highlight key issues not covered in other reports in the Board pack and which the Board should be aware of. The report will consider the following areas:</p> <ul style="list-style-type: none"> <li>• National Topics of Interest</li> <li>• Integrated Care System Update</li> <li>• Strategy and Culture</li> <li>• Operational Delivery</li> <li>• Engagement &amp; Service Visits</li> </ul>			
<b>Strategic Alignment</b>			
This report highlights work that aligns with the Trust's strategic priorities.			
<b>Risks and Opportunities</b>			
N/A			
<b>Recommendation</b>			
This report is for Information. The Trust Board is asked to note the contents of this report.			
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>			
N/A			
<b>Appendices:</b>	N/A		

## Joint Chief Executive's Report

### Background

This report sets out briefing information for Board members on national and local topics of interest.

### 1. National Topics of Interest

#### 1.1 Priorities and Operational Planning Guidance 2025/26

On 30 January 2025, NHS England published the *Priorities and Operational Planning Guidance 2025/26*, confirming the ambitions referenced in the Reforming Elective Care document.

The national priorities to improve patient outcomes in 2025/26 are outlined as:

- Reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5%-point improvement. Systems are expected to continue to improve performance against the cancer 62-day and 28-day Faster Diagnosis Standard (FDS) to 75% and 80% respectively by March 2026
- improve A&E waiting times and ambulance response times compared to 2024/25, with a minimum of 78% of patients seen within 4 hours in March 2026. Category 2 ambulance response times should average no more than 30 minutes across 2025/26
- improve patients' access to general practice, improving patient experience, and improve access to urgent dental care, providing 700,000 additional urgent dental appointments
- improve patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds, and improve access to children and young people's (CYP) mental health services, to achieve the national ambition for 345,000 additional CYP aged 0 to 25 compared to 2019

To achieve these priorities for patients and service users, ICBs and providers, with the support of NHSE, must collaborate to:

- Implement reforms to support the immediate priorities and prepare the NHS for the future. In 2025/26, ICBs and providers should work to reduce demand by developing neighbourhood health service models to prevent long and costly hospital admissions, and improve timely access to urgent and emergency care, maximise opportunities associated with shifting service delivery from analogue to digital, and tackle inequalities including a focus on secondary prevention.
- Operate within the allocated budget, reducing waste and improving productivity, and working to achieve a balanced financial position.
- Prioritise the overall quality and safety of services, with focus on improving challenged and fragile services, such as maternity and neonatal care.

NBT are working with UHBW and the BNSSG ICS in order to ensure that local planning responds to both the national priorities and the needs of our local population. Headline

submissions were made to NHSE on 27 February with final submission due on 27 March 2025.

## **2. Integrated Care System Update**

### **2.1 ICB Leadership Changes**

Sarah Truelove, Chief Finance Officer and Deputy Chief Executive of Bristol, North Somerset, and South Gloucestershire (BNSSG) ICB since 2018 will take over as CEO of Gloucestershire ICB later this year. Sarah has brought strong financial leadership to the BNSSG system and has been an exemplar for partnership working. We wish Sarah all the best in her new role in Gloucestershire.

## **3. Strategy and Culture**

### **3.1 National Staff Survey Results**

The publication of the 2024 National NHS Staff Survey results took place earlier this month and included the full benchmarking report. The Trust saw its highest ever response rate at 62% which is 13% higher than the national average. The Trust is, for the second year running, the best place to work in the South West, but has for the first time this year been rewarded with being the number one Trust in the South West for recommending care to a friend or relative (with UHBW a close second). A total of 86% of the results for the Trust are the same or better than the national average.

### **3.2 Current Performance**

The Urgent and Emergency Care position has remained challenging with continued high bed occupancy. The NCTR position has been static around the 21% mark, which is still a considerable amount above the 15% ambition for BNSSG. There is continued work taking place through the UEC programme, with a specific focus on pathways and increased utilisation of Same Day Emergency Care (SDEC), to ensure patients are seen in the most appropriate service away from the Emergency Department.

The Trust has 339, 52-week patients in February and are moving towards clearance in April 2025. This is currently the lowest number of 52 week waits when compared to other Trusts in the South-West and represents less than 1% of the total waiting list. The diagnostic standard has been met consistently over previous months and it is expected that this is maintained throughout 2025/26.

Cancer performance deteriorated for January, which was predicted and reported. Realistic recovery plans are in place to deliver improvements in March. Our Faster Diagnosis Standard performance remains strong, and improvements have been made in gynaecology where there have been previous performance challenges.

### **3.3 Joint Executive Meetings with Sirona Care and Health and Avon Wiltshire Mental Health Partnership NHS Trust (AWP)**

Over the last two months the NBT and UHBW Executive teams have met with Executive counterparts from two of our system partner organisations.



Discussions with colleagues from Sirona focussed on “no criteria to reside” numbers and opportunities for greater provider-level collaboration to move care pathways from hospital into the community. Specific areas for joint action included more integrated therapy team working, consideration of risk appetites and thresholds, and single managed service opportunities in diabetes care.

Separately, AWP colleagues shared their Community Transformation Programme for a Needs-led Offer, and we discussed work to improve support for eating disorders, and mental health crisis response developments. We agreed to establish regular forum for our clinical and operational executives to collaborate on improving transitions across acute and community pathways for Drug and Alcohol, Emergency Mental Health Care and Learning Disability services.

### **3.3 Supporting the Government's 10-year plan engagement:**

Over the past few months, both NBT and UHBW have been actively supporting the Government's NHS 10-Year Plan engagement campaign, working closely with NHS England and BNSSG ICB to ensure our staff and stakeholders have a real opportunity to contribute. Through our internal communications, we've made sure staff are not only well-informed but also encouraged to share their insights, helping shape the future of the NHS from the frontline. Beyond this, we have played a key role in regional engagement, supporting NHS England and BNSSG ICB in bringing together different voices to discuss the challenges and opportunities ahead. I was also pleased to chair a public event hosted by the ICB—an invaluable opportunity to hear directly from members of our community. The conversations were thoughtful, honest, and energising, reinforcing just how important it is that we continue to create spaces for open dialogue as we plan for the future of our health service.

### **3.4 SWAG Cancer Alliance Annual Conference**

As Chair of the SWAG Cancer Alliance, I was invited to open the annual conference earlier this month. The event was held in Taunton and saw around 200 delegates from across the region representing a number of sectors, including NHS, social care, charity and voluntary organisations and a number of patient representatives. The focus of the event was how SWAG, and the organisations within it, can help to improve cancer survival rates by accelerating its Earlier Diagnosis Strategy and delivering the NHS Long Term Plan ambition of '75% of cancers diagnosed at Stage 1 and 2 by 2028'.

### **3.5 NHS Impact Meeting**

I have attended two National Improvement Board meetings since the last report. The business plan for 2025-26 has been refined and is now focused on delivery of the following key objectives:

- Establish a joined-up system for improvement across the NHS, its partners, and the communities it serves.
- Develop the skills and capability of NHS Managers and leaders in improvement and system leadership.
- Accelerate both the small steps of continuous improvement and the bigger leaps of radical transformation

- Create an NHS wide learning system to more rapidly spread innovation, reduce unwarranted variation and enable sharing of practice from “the best of the NHS to the rest of the NHS.”

### **3.6 Community Engagement meeting – Bristol City Robins and Bristol Sport Foundation**

Dan White, CEO of the Bristol City Robins Foundation and Sarah Mortiboys of the Bristol Sport Foundation met with me recently. The meeting discussed how we can work together to look at initiatives to support young people across the city. This is one of the partnerships we are working on with community organisations as an anchor and as a key partner in the work to reduce youth violence.

### **3.7 Preventing Serious Violence Partnership Board**

At the last meeting on 10 March, the NHS perspective/offer was present to all of the local organisations involved in this meeting. There has been engagement from a number of different community and local authority bodies regarding the role that the Trust can play. In the meantime internal workstreams continue to evolve the Trust's response to victims of violence who attend the hospital, as well as how we can further outreach into the wider community.

## **4. Engagement and Visits**

### **4.1 Visit from The Princess Royal**

The Joint Chair and I were very pleased to be able to welcome Her Royal Highness Princess Anne on her recent visit to the Trust. The Princess undertook a tour of the ICU where she was treated in June 2024 following her admission after an incident at her estate in Gloucestershire. The Princess was personally introduced to a number of staff members who had been involved in her care whilst she was an in-patient, including medics, nurses, AHPs and emergency department team members. The critical care team from Great Western Air Ambulance Trust and paramedics from South Western Ambulance NHS Foundation Trust also were invited to meet the Princess, who was also treated to a performance from our ICU staff choir.

### **4.2 Strategic Partnership Event**

The first of what I hope will be a regular Strategic Partnership Event took place on 26 February. The event brought together key stakeholders from across the city, system and region with a mixture of NHS, Local Authority, business, care and voluntary organisations being represented. The focus was to engage these partners in interactive sessions, sharing the work we have been doing on the development of the Group and our Joint Clinical Strategy, and to gain their input and insights. Both the Joint Chair and I were very grateful to the communication teams who have worked so hard on pulling the event together and to our Executive colleagues who helped to facilitate the breakout sessions.

### **4.3 Visit to North Bristol Community Diagnostic Centre with the Prime Minister, Sir Keir Starmer**

In February we were also very grateful to welcome the Prime Minister for a visit to the North Bristol Community Diagnostic Centre. We were also joined by representatives for InHealth, the company which runs the centre on behalf of the NHS and who have already provided over 23,000 appointments for patients across Bristol in the past nine months. This was following the Government's announcement that they had met a pre-election target of delivering an additional two million extra appointments across the NHS. Sir Keir was taken on a tour of the centre and shown the equipment and scanners which are used there. The Prime Minister had a number of questions about how the centre operated and was keen to learn about how the centre was reducing waiting times for diagnostic tests.

#### **4.4 Service Visits**

I have been able to go and see a number of areas across the Trust over the past two months. These visits provide me with an opportunity to speak to frontline staff – clinical and non-clinical as well as our wonderful volunteers – and hear about their great ideas and of their challenges. Over the past few weeks I have met with colleagues from ICU, Facilities, Surgery and Emergency Medicine.

#### **Recommendation**

The Board is asked to note the report.

**Maria Kane**  
**Joint Chief Executive**

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Volunteer Services Strategic Plan 2025-2028		
<b>Report Author:</b>	Kathryn Tudor-Thomas, Volunteer Service Manager		
<b>Report Sponsor:</b>	Steve Hams, Chief Nursing Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
	X		
	The Volunteer Services Strategic Plan 2025-2028 summarises the service achievements, opportunities, and looks at four key objectives to diversify and improve our service.		
<b>Key Points to Note</b> <i>(Including any previous decisions taken)</i>			
<p>Our established team of over 400 volunteers donate their time to improve the experience for our patients, staff, and visitors across our hospital sites. Our volunteers support our patients in unique ways and support our staff to deliver patient-centred care.</p> <p>Our previous strategic plan (2021-2024) focused on making operational improvements to recover the service following the Covid-19 pandemic.</p> <p>The purpose of our new strategic plan puts inclusive practices, continuous learning, and a welcoming culture at the heart of all we do. We want to elevate our service to diversify our pool of volunteers, break down barriers to volunteering, further improve the experience for our patients and volunteers, and bring our service into a modern era where our systems are fit for purpose.</p> <p>We are focusing on four key objectives to transform our service from the start of the volunteer journey to the patients who are at the heart of our service:</p> <ul style="list-style-type: none"> <li>• Objective one: Foster a culture of inclusivity throughout our service, with the aim to break down barriers to volunteering with us, and in turn diversify our pool of volunteers.</li> <li>• Objective two: Improve the experience for our patients through enhancing our existing volunteer offer.</li> <li>• Objective three: Develop the volunteer journey to provide an individualised and supportive experience with an open and welcoming culture.</li> <li>• Objective four: Modernise our systems to manage our data, more widely capture our impact, and embrace the Group Model.</li> </ul> <p>We have created a 3-year action plan which compliments the Patient Experience and Carer Experience Strategy to drive forward our objectives.</p>			

<b>Strategic and Group Model Alignment</b>	
<p>Our strategic plan has been co-designed through conversations with staff, volunteers, and voluntary sector partners. It has also been influenced by the Trust Strategy, Joint Clinical Strategy, Patient and Carer Experience Strategy, internal audit and CQC Quality Statements.</p> <p>Our four key objectives align with the Trust's strategic direction and improvement priorities and each focus on:</p> <ol style="list-style-type: none"> <li>1. Anchor in our Community</li> <li>2. Outstanding Patient Experience</li> <li>3. Proud to Belong</li> <li>4. Unlocking a Better Future</li> </ol> <p>Our fourth Objective is inspired by our Group Model approach and embraces the opportunity to work more closely alongside University Hospital Bristol and Weston Foundation Trust (UHBW) Volunteer Services. We see a great long-term benefit to aligning our recruitment process and policies. The alignment of our services brings the advantage to share volunteers across both sites, providing a consistent volunteer experience between both Trusts, and deliver joint training opportunities.</p> <p>UHBW's recent implementation of Volunteer Management software will be an opportunity for us to understand the advantages and disadvantages of this programme and may be an opportunity for us to explore the implementation of the software to manage our volunteer database and rota system. Achieving our aim to modernise our systems to streamline and more efficiently manage our data and record the volunteer impact.</p>	
<b>Risks and Opportunities</b>	
<p>The Volunteer Services Strategic Plan is not linked to any associated risk on the risk register.</p> <p>Our service recognises the importance and value of a diverse volunteer workforce. To achieve this, we have the opportunity to learn and listen to our community to understand the barriers to volunteering and how we can improve our recruitment practices, culture and support.</p>	
<b>Recommendation</b>	
<p>This report is for <b>Approval</b></p> <p>The Board is asked to approve this strategic plan.</p>	
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>	
<p>An overview of the strategic plan has been shared with the following groups for comment:</p> <p>Dementia Strategy Group</p> <p>Patient and Carer Experience Group</p> <p>Carer Strategy Meeting</p> <p>Patient and Carer Partnership Group</p> <p>Divisional Patient Experience Group</p>	<p>4/3/2025</p> <p>17/2/2025</p> <p>11/2/2025</p> <p>4/2/2025</p> <p>16/1/2025</p>

The final plan for approval has only been submitted to Trust Board.	
<b>Appendices:</b>	<p><i>Appendix 1: Volunteer Services Strategic Plan 2025-2028</i></p> <p><i>Appendix 2: Volunteer Services Strategic Plan A4 Page At a Glance</i></p> <p><i>Appendix 3: Volunteer Services Strategic Plan Covering Report</i></p> <p><i>Appendix 4: Equality Impact Assessment (EIA)- Volunteer Services Strategic Plan.</i></p>

## 1. Purpose

- 1.1 The Volunteer Services Strategic Plan 2025-2028 sets out the service achievements, opportunities, and looks at four key objectives to diversify and improve our service over the next three years. We are asking for Trust Board to approve this strategic plan.

## 2. Background

- 2.1 Our established team of over 400 volunteers donate their time to improve the experience for our patients, staff, and visitors across our hospital sites. Our volunteers support our patients in unique ways and support our staff to deliver patient-centred care.
- 2.2 Our previous strategic plan (2021-2024) focused on making operational improvements to recover the service following the Covid-19 pandemic.
- 2.3 This strategic plan has been developed to drive us forwards with and clear and ambitious vision for the future. Please see Appendix 1.

## 3. Overview of the strategic plan

- 3.1 The purpose of our new strategic plan puts inclusive practices, continuous learning, and a welcoming culture at the heart of all we do. We want to elevate our service to diversify our pool of volunteers, break down barriers to volunteering, further improve the experience for our patients and volunteers, and bring our service into a modern era where our systems are fit for purpose.

Our strategic plan has been designed through conversations with staff, volunteers, and voluntary sector partners. It has also been influenced by the Trust Strategy, Joint Clinical Strategy, Patient and Carer Experience Strategy, internal audit and CQC Quality Statements.

To support the development of the strategic plan we wrote a covering report which displays an in depth break down and cross section of our volunteer demographics by year, team, and in comparison, to NHS England data, our NBT staff workforce, and BNSSG population (2021 census). This has given us a richer understanding of our volunteer teams and formed a basis for our initial decision making around our approach to diversifying our pool of volunteers. Please see Appendix 3.

We are focusing on four key objectives to transform our service from the start of the volunteer journey to the patients who are at the heart of our service:

- Objective one: Foster a culture of inclusivity throughout our service, with the aim to break down barriers to volunteering with us, and in turn diversify our pool of volunteers.
- Objective two: Improve the experience for our patients through enhancing our existing volunteer offer.

- Objective three: Develop the volunteer journey to provide an individualised and supportive experience with an open and welcoming culture.
- Objective four: Modernise our systems to manage our data, more widely capture our impact, and embrace the Group Model.

We have created a 3-year action plan which compliments the Patient Experience and Carer Experience Strategy to drive forward our objectives.

- 3.2 We will approach our objectives in an authentic way that does not assign specific KPI's to increasing our pool of volunteers, which risks tokenism and volunteers feeling they have been targeted to fill a quota.

We have completed an Equality Impact Assessment for this strategic plan which is awaiting approval. This states the impact of equality benefits, risks and mitigations our plan has identified. Please see Appendix 4.

- 3.3 We have used a selection of text and imagery to demonstrate to the reader the vibrant tone of our service and displayed a range of volunteer portraits, role profiles and infographics. We have made use of a spider diagram to demonstrate the wide network of services and departments we will engage with to achieve our objectives. We have received positive feedback that this design is well laid out and easy to follow.
- 3.4 We have designed an accompanying one-page accessible summary of our strategic plan to increase engagement and highlight our key messaging to a wider audience. Please see Appendix 2.
- 3.5 The new strategic plan takes into account the context of our hospital and the Group Model approach with UHBW. We are embracing the opportunity to work more closely and align our services.

#### **4. Summary and Recommendations**

- 4.1 The Board is asked to approve this new strategic plan.



# Volunteer Services



Strategic Plan 2025-2028



# Foreword

“ Our volunteers are an integral part of our NBT family. ”

We are privileged to have an established team of over 400 volunteers delivering up to 30 different volunteer roles across North Bristol NHS Trust (NBT). Whether the volunteer role is supporting our wards, directing our outpatients, providing peer support, or fundraising for our hospital charity, each supports our patients and truly contributes to meeting our Trust aim to deliver an outstanding patient experience.

As I reflect on the impact our volunteers make, I think about how I have seen firsthand the vital role they play in bringing comfort, companionship, reassurance and joy to our patients and their loved ones. They are also an invaluable voice to shape our hospital services, through their own lived experience, or through speaking and listening to patients.

Personally, I have enjoyed a cup of tea at our League of Friends at Cosham and Southmead, benefitted from listening to the music provided by our Fresh Arts musicians, and enjoyed meeting our furry friends with Pets as Therapy!

This strategic plan places diversity and inclusion at its heart. The plan embraces the opportunity to reach out to our local community to understand the barriers faced by those who wish to volunteer with us. Striving towards our Trust objective of being an anchor in our community.

A strong theme resonates through this plan, to work collaboratively through existing community links, to achieve our Trust objectives. Not only to expand the support provided by our volunteers to the hospital, but to enhance the volunteer journey too.

In keeping with our Trust values, the new mission statement signifies our ambition to shift from sustaining our volunteer service to enhancing its success through a philosophy of continuous improvement, championing new ideas and innovation.

Finally, I want to thank all our volunteers for dedicating your time, passion, and energy, and placing patients and staff at the heart of everything you do. You are a hugely valued part of the 'NBT family' and we are so grateful to you all. I am pleased to introduce this strategic plan to build on your excellence and to continue to improve patient experience for many more years to come.

**Professor Steve Hams**  
Chief Nursing Officer



# Our Volunteers

We know how valuable volunteering is to our volunteers.

**Istar,**  
Ward Support Volunteer



“ I have been involved with the hospital as a Patient Partner...I became involved through the Bristol Sight Loss Council. I thought it was a good way to feed into services from my own personal experience. ”

**Bob,**  
Move Maker



“ I volunteer because I enjoy helping people. It runs on from when I was a postman and was always willing to help people on my rounds! ”

“ I volunteered to gain some experience in a hospital setting ahead of applying to study Adult Nursing. Everyone was so welcoming and friendly... and I now have an offer of a place to study Adult Nursing at university. ”



**Patient and Carer Partner**



# Our Previous Strategic Plan

Our previous strategic plan (2021-2024) focused on making operational improvements to help recover the service following the Covid-19 pandemic. We reviewed our volunteer role descriptions, moved our recruitment process on to Trac, we returned our volunteers safely to their roles, and created new ones that enhanced the patient experience. At the forefront of our ways of working was keeping our volunteers and patients safe.

## Key successes:

- We worked with Bristol Sight Loss Council to train our volunteers and staff to guide a patient, and create a supportive way for visually impaired patients to seek assistance for their appointments.
- We brought all our volunteers together under one central recruitment process and made our training more accessible through supportive literature and in person E-Learning support. However, we recognise our required mandatory training to be a barrier to some for volunteering, and we endeavour to make this more interactive.
- We created a new Volunteer Handbook, opened a social media platform, improved our intranet and website pages, the latter becoming the key entry point for many volunteers to apply with us through our online process.
- We forged relationships with SGS College and NHS Cadets which opened up opportunities for young volunteers to join our team. We are looking forward to building on this experience in the coming years.
- We created new roles, such as our Adverse Weather drivers, Mealtime Companion, Purple Butterfly, Patient Feedback volunteer, Patient Buddy Role and our Maternity volunteer.

## Looking forward

There were two key areas where we did not meet our objectives. We missed the opportunity to introduce a volunteer survey, a priority which we will bring forward to our new strategic plan.

We also fell short of our original KPI of 35% of our team being aged under 50, achieving 28% in 2024, an increase of 4% since 2020. In our new strategic plan, we will carry forward and broaden our ambition to radically change our culture, to understand the barriers to volunteering for those with different protected characteristics and become an appealing and supportive environment for everyone who wishes to volunteer.

For more information about the demographics of our volunteers please contact [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) for a copy of our report.





# Purpose

**We are excited to look ahead to the future. The purpose of this ambitious strategic plan puts inclusive practices, continuous learning, and a welcoming culture at the heart of all we do. We want to elevate our service to diversify our pool of volunteers, break down barriers to volunteering, and further improve the experience for our patients and volunteers. We will bring our service into a modern era where our systems are fit for purpose.**

This strategic plan has been designed through conversations with staff, volunteers, and voluntary sector partners. It has also been influenced by the Trust Strategy, Joint Clinical Strategy, Patient and Carer Experience Strategy, internal audit and CQC Quality Statements. Our Volunteer Service vision is:

In this strategic plan we are focusing on four key objectives to transform our service from the start of the volunteer journey to the patients who are at the heart of our service. Further details of our work plan to support these objectives is available upon request at [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk)



**“ To deliver an inclusive, supportive, and safe Volunteer Service, driven by continuous learning and our commitment to put the patient experience at the heart of everything we do. ”**



# Objectives

We will;

## Objective one:

Foster a culture of inclusivity throughout our service, with the aim to break down barriers to volunteering with us, and in turn diversify our pool of volunteers.



## Objective two:

Improve the experience for our patients through enhancing our existing volunteer offer.



## Objective three:

Develop the volunteer journey to provide an individualised and supportive experience with an open and welcoming culture.



## Objective four:

Modernise our systems to manage our data, more widely capture our impact, and embrace the Group Model.



# Objective One: Foster a culture of inclusivity

Trust Objective Link:  
Anchor in our Community



We recognise the importance and value of a diverse volunteer workforce. To achieve this, we need to learn and listen to our community to understand the barriers to volunteering and how we can improve our recruitment practices, culture and support. This is our **priority commitment** because it will embed a new way of working which will influence all our other service actions, we know this will take time and commitment to achieve properly.

**“We understand that we will only make real progress if we all proactively ‘own’ and are responsible and accountable for the EDI agenda and delivery of change.”**

- NBT EDI 3 year Plan



### Our volunteer demographics

In June 2024 we looked at the demographics of 366 of our active volunteers, this analysis did not include the League of Friends Cossham, who have a volunteer team of 71, due to our independent data gathering methods. We were also able to cross reference this data with the same gathered in February 2020 and February 2023.

Our covering report displays an in depth break down and cross section of our demographics by year, team, and in comparison, to our NBT staff workforce and BNSSG population. This has given us a richer understanding of our volunteer teams and formed a basis for our initial decision making around our approach to diversifying our pool of volunteers.

### Culture not quota

As the saying goes, culture eats strategy for breakfast. We know that in order to meet this objective we need to embed diversity and inclusion into our values and at the heart of our culture. Any required changes to processes should follow this. We need to work with our community partners to understand the barriers people may face to volunteering with us and how we can overcome them.

We aim for an increase in the number of volunteers aged between 17-30, a larger number from a global majority background and more volunteers who identify as having a disability.

We do not see this as a tick box exercise! We want to approach this in an authentic way that fosters a genuine welcome and open culture without assigning specific KPI's which risk tokenism and volunteers feeling they have been targeted to fill a quota. The following approach sets out our initial plans to foster a welcoming culture, reach out to our local community, understand and overcome barriers, and work in collaboration across the Trust.

# We recognise four key themes to support this

1.

## Forging strong cross-departmental relationships and utilising their community links

We know that there is a wealth of work and knowledge across NBT to work towards the Trust commitment to be an anchor in community. Whilst we have historically forged our own community links, we feel that working closely with others and aligning our practices will bring a greater benefit to the communities we serve. This will not only allow for greater cohesion, but also will ensure that we are as informed as we can be before approaching specific community groups.

**We aim to work with the existing experts to understand local health inequalities and ask our community what barriers they experience to volunteering.**

2.

## Volunteer Role Promotion Opportunities

The locations in which we promote our volunteering opportunities will be integral to reaching a wider audience.

**We will work closely with the central Communications and Talent teams to promote our roles, and we will look at ways to be creative, accessible, and inclusive with our messaging and imagery to attract a wide range of volunteers.**

3.

## Ensuring our recruitment staff are trained ...

As a staff team, it is important that we are all open to genuinely understanding the benefits of a diverse volunteer team and the value this brings to our patients, visitors, and staff. Even if something has worked well before, we understand that it might not be the right process for us now. It is important for us to recognise our bias's, embrace and be open to change, and continuous learning.

**We will ensure meaningful, up to date, Equality, Diversity, and Inclusion training for our staff team. Exploring scenarios from our recruitment practices and recognising where we can improve.**

## ...and our interview panels are diverse

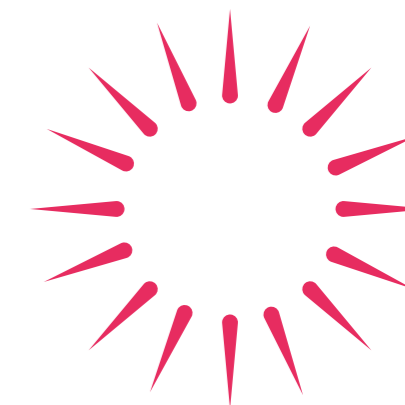
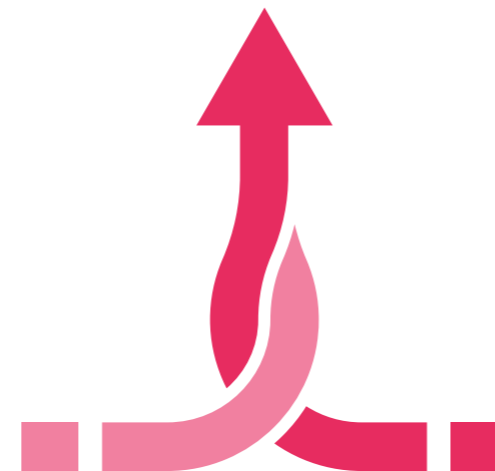
Recent research from the NVCO tells us that "a culture of trust and respect, recognition, and a sense of belonging are particularly important to people from the global majority. These factors influence overall satisfaction with volunteering". To help mitigate unconscious bias and groupthink, we will strive to have representation on our interview panel from a volunteer or staff member who can act as an ambassador. This individual may be from a global majority background, have a disability, or other protected characteristic.

4.

## Reviewing our Recruitment process

The NHS Volunteer recruitment process follows a robust and structured approach to ensure that we are upholding our duty of care to our patients by implementing a safe recruitment process. Conducting a DBS check, two reference checks, an Occupational Health review and a suite of mandatory training can be a long process which some applicants find demanding and off putting.

**We are committed to ensuring our process is safe, however we recognise that we can learn from other Trusts to understand how they may have streamlined their recruitment and training process to make the journey smoother and our training more accessible to volunteers.**





“ Ultimately, effective recruitment ensures that the volunteer department is well-positioned for success, providing a strong foundation from which volunteers can thrive and make a meaningful impact. ”  
 - Helpforce







# Objective Two: Enhance our Existing Volunteer Offer

**Trust Objective Link:**  
Outstanding Patient Experience



Our Volunteer Service proudly sits within the Patient Experience Team. In conjunction with this strategic plan, we have committed to objectives that contribute to the wider patient experience through the Patient and Carer Experience Strategy 2023-2026. Our patients are at the heart of everything we do, and our volunteers play an important role in not only improving their experience but also gathering impact and patient stories which will inform broader changes across the hospital. This gathering of patient feedback not only meets the CQC statement that NBT “make it easy for people to share feedback and ideas”, but it is also a key mechanism to measure the outcome of our Trust objective to achieve an outstanding patient experience.

We know that 14% of our patients’ interactions at NBT involve a mental health diagnosis. **We will support our NBT’s Mental Health Strategy by equipping our**

**volunteers to be confident and able to offer appropriate support and interact with patients who may need additional support as they enter our hospital.**

**“To ensure all our workforce are capable of recognising and responding appropriately to a patient with mental health needs”**

- The North Bristol NHS Trust Clinical Strategy

Southmead Hospital Charity has a small team of dedicated volunteers who support with fundraising and events. To support their volunteer team to expand and become more sustainable in the long term we will work alongside them and the communications team to ensure that targeted advertising increases interest in the role. The nature of the occasional events could be an opportunity to advertise more flexible short-term roles to both our staff and younger volunteers.

We work alongside and collaboratively with our colleagues in Chaplaincy, PALS and Complaints, and Fresh Arts. All of which directly support and manage their own teams of volunteers. These volunteers

bring specialist support, lived experience of using our hospital, and provide music and creative arts to benefit our patients, visitors, and staff. **We have identified objectives within our action plan which specifically focus on improving and broadening these volunteer roles**, as well as supporting our Hospital Charity and training for our volunteers.

Lastly, **we will consider how we can expand our volunteer offer to include staff.** The five ways to wellbeing show the value of volunteering, and how connecting with others, learning new skills, and giving your time can improve your mental and physical wellbeing.

**“Our Clinical Strategy commits to developing our strong positive culture by prioritising staff wellbeing, empowering staff to drive transformation, and celebrating and sharing success.”**

We know that our NBT staff have a wealth of knowledge, skills, and ideas that can improve the experience of our patients and we will explore how to promote the benefits of volunteering not just internally but externally to encourage community links and improve staff wellbeing.



# Objective Three: Develop the Volunteer Journey

**Trust Objective Link:**  
Proud to Belong



**“Recruitment is just the beginning. Retaining volunteers is the linchpin that ensures the enduring success of your program. Through recognition, feedback, and a commitment to their growth, you can create an environment where volunteers feel valued, supported, and inspired to continue their vital service.”**

- Helpforce

We want to provide a high-quality service which truly cares, supports, values, and nurtures our volunteers. It is important that the volunteers have a voice to shape our service, and that they feel they are

supported by our staff as well as the departments they volunteer within. We want them to have a smooth experience from start to finish on their volunteer journey and feel that they are well equipped to conduct their role and support our patients.

**We will provide more opportunities for our volunteers to express their feedback and ideas.** We want our volunteers to feel connected with each other, understand what the wider volunteer and Patient Experience team are accomplishing and be able to easily access wellbeing support. We will commit to conducting an annual volunteer survey to provide the volunteers with an opportunity to feedback anonymously about their volunteer journey. Furthermore, we will explore additional feedback and support opportunities, such as formalised supervision sessions and volunteer peer support.

We know that volunteering is a well-recognised route into employment for the NHS as well as providing a platform for students considering medical, nursing, and allied health professional degrees. This is reflected in the national NHS long term plan

and our Trust's clinical strategy which aims to provide “investment in workforce to support volunteers and new entry routes for staff e.g. apprenticeships.”

**We will grow our pool of young adult volunteers, including our NHS Cadets,** to support the next generation of the NHS workforce. To do this we want to forge greater relationships with our local colleges and universities, and stronger links with our apprenticeship and work experience programmes. **We want to work towards seeing a clear volunteer to career progression for our volunteers** who are looking for health care opportunities. These are big ambitions which will take time to establish, and our approach may evolve as we receive feedback and shape our actions on our volunteer responses.







## Objective Four: Modernise Our Systems

**Trust Objective Link:**  
Unlocking a better future



In February 2024 we received the results from an external audit of our volunteer recruitment process, this was an important time for us to reflect on what processes could be improved. We have already started implementing actions to address the recommendations made. **We will complete all of these actions to ensure we have clear evidence to demonstrate the basis of our recruitment decisions.** Establishing those actions has highlighted an area for development within our volunteer management systems.

**We will explore Volunteer Management systems to improve the efficiency of our service.** As stated in our Clinical Strategy "investing in technology can reduce strain on workforce, improve the sustainability of healthcare and offer a better experience to patients." In the context of our service, modernising our approach will secure a sustainable and efficient future. It will also enable us to improve our local and

national reporting and demonstrate the incredible impact our volunteers have.

Inspired by the ambitions of Our Joint Clinical Strategy and our group model approach, **we will embrace the opportunity to work more closely alongside University Hospital Bristol and Weston (UHBW) Volunteer Services.**

Key areas include;

- We see a great long-term benefit to aligning our recruitment process and policies, where appropriate.
- We recognise that they will have different ideas and approaches that we would benefit from shadowing and learning from.
- Their recent implementation of Assemble Volunteer Management software will be an opportunity for us to understand the advantages and disadvantages of this programme and may be an opportunity for us to explore implementation of the software to manage our volunteer database and rota system.





# Governance and reporting

- We will provide a summary report on the progress of the strategic action plan quarterly to the Patient and Carer Experience Group (PCEG) meetings, as recommended by our KPMG audit. This will include an annual update on our volunteer demographics.
- We will also continue to attend and report into the Divisional Patient Experience Group, Patient and Carer Partnership Group, Carers Strategy Group, Dementia Strategy Group and JCNC subgroup when appropriate.
- We will contribute a summary of our activities in the Patient and Carer Annual Experience Report and the NBT Quality Account.
- We will provide our volunteer statistics to the NHS National Data Collection framework, in keeping with the requirement by NHS England to provide statistics on the number of volunteers we have, the hours they donate, and their demographic information.
- We will audit our volunteer files on a bimonthly basis to ensure compliance rates are maintained.







# Who we will work with





## NHS Cadets



Volunteer Services are proud supporters of the St John Ambulance NHS Cadets scheme, enrolling students into our volunteer roles to give them experience within the hospital environment.



“ I always knew I wanted to work in the NHS but wasn't sure what role to pursue. Being an NHS Cadet with St John has really helped me narrow down what I want to do – I can't wait to start my career as a paramedic. ”

Sumia, NHS Cadet and NBT Volunteer

## Peer Support Volunteer



We are privileged to have many peer support volunteer roles throughout different specialities. They use their lived experience to support our current patients.

“ I am part of the Kidney Peer Mentor Group and I speak to and support people who are about to start dialysis, need to start dialysis, or are already having dialysis. I know that getting diagnosed with renal failure can be quite daunting to a lot of people. It is nice when the patients I've been supporting feel safe to speak to me when they're anxious about anything and they seem really grateful– I've been described as “a Godsend”. ”

Adebomi, Kidney Peer Support Volunteer

## Patient Experience



## Survey Volunteer

Our survey volunteers gather and encourage feedback from our patients and people who look after them at home.

“ This is a great way of obtaining real time patient experience... I have enjoyed meeting and chatting to a wide range of patients on different wards. ”

Val, Patient Experience Volunteer

## Move Maker



Our Move Makers are often the first interaction our outpatients or visitors have when they arrive at our hospitals. They strive to make everyone's visit as welcoming and stress-free as possible.

“ When I retired, I initially cared for my wife, but after she passed away, I found I had time on my hands and I missed the workplace. I wanted to stay active, physically and mentally, and use some of my life and business skills. Being a Move Maker gives me a sense of purpose, a reason to get up in the morning, and the satisfaction of doing something worthwhile. Oh... and I really enjoy it! ”

John, Move Maker

## Patient Befriender



## Volunteer

Our patient befrienders offer company and companionship to our ward based patients to help reduce feelings of isolation and loneliness.

“ I know what it is like to be in hospital for a long time, as a patient, and how isolating that can feel, so the best thing about volunteering for me is cheering people up and letting them know that they're not alone. ”

Stewart, Patient Befriender Volunteer

# Volunteer Profiles

If you would like this document in an alternative format, please contact the Volunteer Services Team at [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) or 0117 414 0110

Se desejar este documento em um formato alternativo, entre em contato com a Equipe de Experiência do Paciente em [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) ou 0117 414 0110

Jeśli chcesz otrzymać ten dokument w alternatywnym formacie, skontaktuj się z zespołem obsługi pacjenta pod adresem [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) lub pod numerem 0117 414 0110

ਜ਼ਕਰ ਤਸੀ ਇਸ ਦਸਤਾਵਜ਼ ਨ ਕਸਿ ਵਕਿਲਪਕਿ ਫਾਰਮਟ ਵੀ ਚ ਚਾਹ ਦ ਹ, ਤਾ ਕਰਿਪਾ ਕਰਕ [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) ਜਾ 0117 414 0110 'ਤੇ ਮਰੀਜ਼ ਅਨਭਵ ਟੀਮ ਨਾਲ ਸ ਪਰਕ ਕਰ।

ی اس سہت اویزکو نپبادل فاریٹ ہں چلتے ہں متوب رلکرم دیضکیت ج پیکوٹھی مہسے  
0117 414 0110 پر یطکریں۔

如果您想要本文档的其他格式，请通过 [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) / 0117 414 0110 联系患者体验团队

As jy hierdie dokument in 'n alternatiewe formaat wil hê, kontak asseblief die Pasiëntervaringspan by [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) of 0117 414 0110

Haddii aad rabto dukumeentigan oo qaab kale ah, fadlan kala xidhiidh Kooxda Khibrada Bukaanka ee [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) ama 0117 414 0110

Kung gusto mo ang dokumentong ito sa alternatibong format, mangyaring makipag-ugnayan sa Volunteer Services Team sa [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) o 0117 414 0110

#### Authors

Kathryn Tudor Thomas, Volunteer Services Manager  
Emily Ayling, Head of Patient Experience  
Paul Cresswell, Director of Quality Governance

With thanks to all who contributed in shaping this strategic plan.

# Volunteer Services

## Strategic Plan 2025-2028



North Bristol  
NHS Trust

### At a glance



**“ We have over 400 amazing volunteers delivering up to 30 different volunteer roles across NBT. Each role supports our patients and delivers an outstanding patient experience. ”**

**Steve Hams,**  
Chief Nursing Officer

### Our Vision:

To deliver an inclusive, supportive, and safe Volunteer Service, driven by continuous learning and our commitment to put the patient experience at the heart of everything we do.

### We have four key aims to transform our service:

#### Objective one:

Foster a culture of inclusivity throughout our service. With the aim to break down barriers to volunteering with us and diversify our pool of volunteers.



#### Objective two:

Improve the experience for our patients through enhancing our existing volunteer offer.



#### Objective three:

Develop the volunteer journey to provide a supportive experience and welcoming culture.



#### Objective four:

Update our systems to manage our data, capture our impact, and embrace the Group Model.



If you would like further details, or if you would like this document in an alternative format. Please contact us on:  
[volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) 0117 414 0110



# Covering Report

## Volunteer Services Strategic Plan 2025-2028

### Purpose

This report sets out a summary of the volunteer services demographic information collected in 2020, 2023 and 2024, with the purpose of analysing this data to inform the direction of our Volunteer Services Strategic Plan.

### 1.0 Introduction

We are excited to look ahead to the future, and we know a key focus of our strategic plan will put inclusive practices, continuous learning, and a welcoming culture, at the heart of all we do. We want to elevate our service to diversify our pool of volunteers, break down barriers to volunteering, and further improve the experience for our patients and volunteers.

To fully understand and reflect on the current demographic position of our volunteer cohort, we have presented in this report the data from up to 366 volunteers during February 2020, February 2023 and June 2024. This approach has given us an opportunity to analyse the changes throughout the last 5 years and draw comparisons between NHS England data, our NBT staff workforce, and BNSSG local population.

The data we collected in this report used our previous demographic criteria and terminology, which limits the scope of our collection. In 2025, we are now able to improve the quality of information we collect on our volunteers, which will match the mandatory quarterly NHS England data collection and align with the Equal Opportunities questionnaire completed by our volunteers through the Trac recruitment system. Appendix 1 displays the specific breakdown and categories we will gather going forwards.

### 2.0 Volunteer Services Demographic Overview

In June 2024 we looked at the demographics of 366 of our active volunteers, this analysis did not include the League of Friends Cossham, who have a volunteer team of 71, due to our independent data gathering methods. We have cross referenced this data with the same gathered in February 2020 and February 2023.

#### Gender

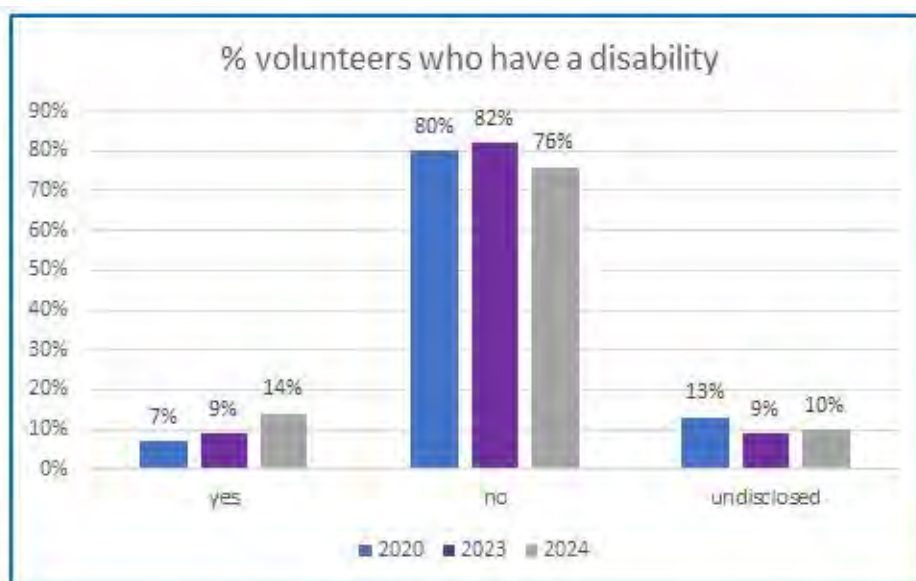
In 2024, 60% of our volunteer work force was female, 39% male and 1% non-binary. Comparatively, in 2020, only 28% of our volunteers were male demonstrating an 11% increase. This rise can be attributed to an increase in male volunteers within our Adverse Weather Driver role, Ward Support and Fresh Arts Musician role.

In comparison to NHS England volunteer workforce gender data collected from NHS Trusts across England (44% female, 21% male, 35% unknown), we are in line with the general trend of more female volunteers donating their time to roles with the health and social care sector.



### Disability

In 2024, 14% of our volunteers identify as having a disability (until 2025, we did not record further details about specific disabilities or if a volunteer has more than one). This is an increase from 7% and 9% in 2020 and 2023 respectively. This increase has been a result of a rise in volunteers within roles that require lived experience as a patient, such as our Pain Management team and Patient and Carer Partners. The Fresh Arts Musicians and our ward support role also has a higher percentage of volunteers with a disability. We aim to continue increasing the number of volunteers who have a disability through evaluating our roles for accessibility and increasing our pool of volunteers with lived patient experience.



### Ethnicity

Our volunteer ethnicity data shows that 88% of our volunteers are from a White background. This is an increase on previous years, however in 2020 and 2023 some of our data was undisclosed for this category and could be masking the true total of those results.

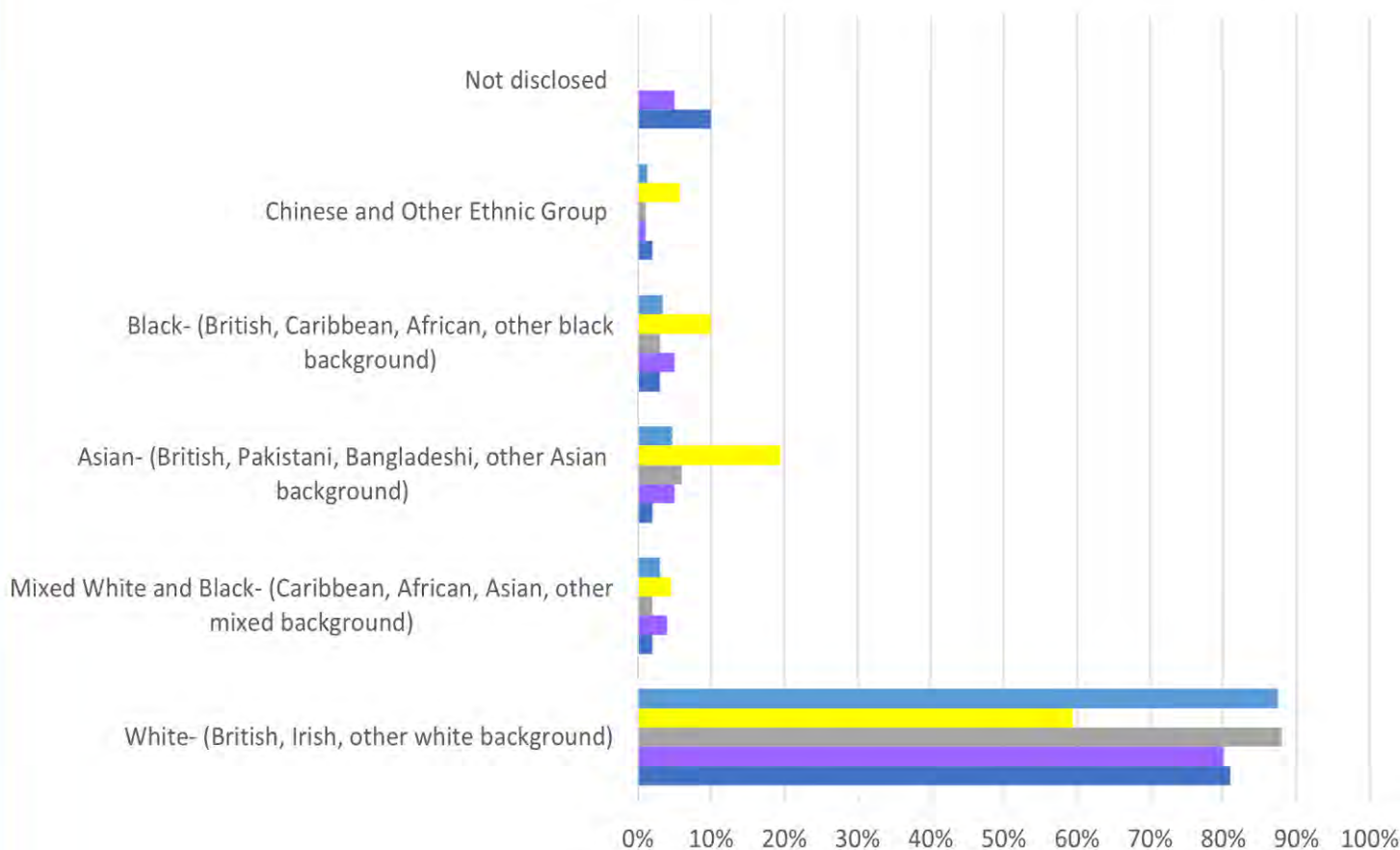
In 2023 we had the highest percentage of volunteers from a global majority recorded at 15%, and we have seen a 4% decline in volunteers from a Black, and Mixed White and Black background. This could be due to the staff changes that took place during May and June 2024, where our focus shifted from recruitment to handover and supporting our current volunteers. Recent research from the NVCO tells us that “a culture of trust and respect, recognition, and a sense of belonging are particularly important to people from the global majority. These factors influence overall satisfaction with volunteering.” This consideration will be taken into account when forming our approach to our objectives.

Our Clinical Strategy states that 87% of our inpatient and outpatient activity is for patients who reside in the Bristol, North Somerset, and South Gloucestershire (BNSSG) area. As a comparable measure we have used BNSSG demographic data from the 2021 census, and our NBT staff data, as a benchmark to compare our volunteer ethnicity.

When comparing this demographic data, we predominantly align with the BNSSG population, however, fall considerably shorter than our staff. We understand that our staff workforce has a variety of workstreams, such as our international nurses, and it would not be a realistic aim to increase the diversity of our volunteers in line with this. However, the diversity of our workforce demonstrates NBT’s commitment to inclusion and is important evidence why diversity is so important within our Trust. We aim to increase the number of volunteers from a global majority background, recovering from our recent decline and aspiring to have a richer pool of volunteers.



### Volunteer Ethnicity alongside NBT staff and BNSSG Population

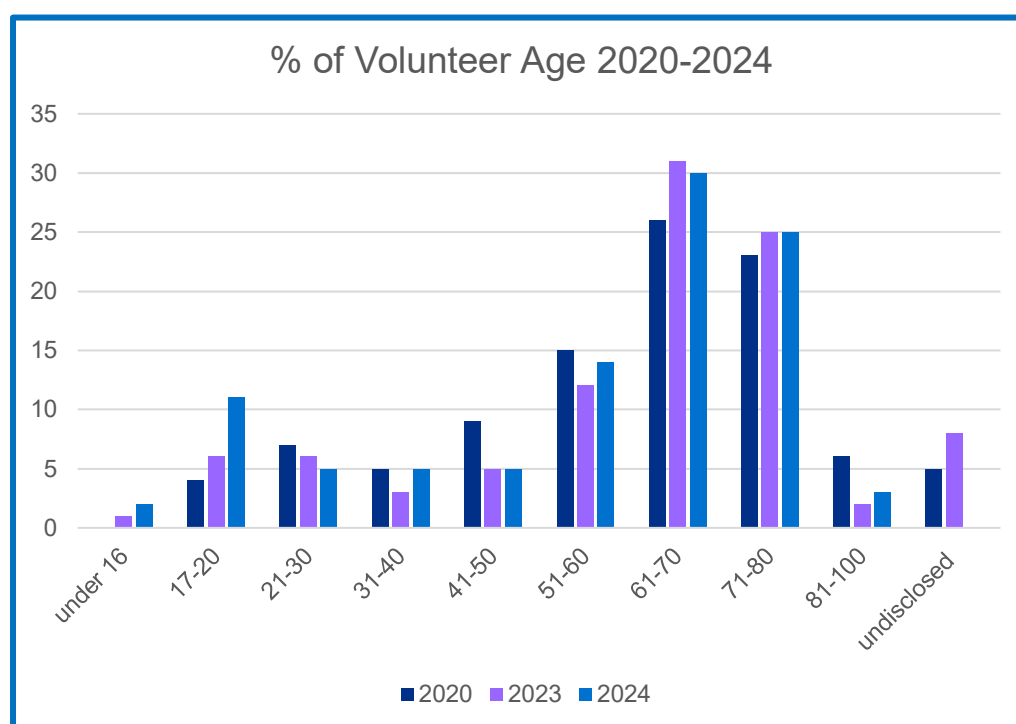


	White- (British, Irish, other white background)	Mixed White and Black- (Caribbean, African, Asian, other mixed background)	Asian- (British, Pakistani, Bangladeshi, other Asian background)	Black- (British, Caribbean, African, other black background)	Chinese and Other Ethnic Group	Not disclosed
■ BNSSG	88%	3%	5%	3%	1%	
■ NBT Staff	60%	5%	20%	10%	6%	
■ Vol 2024	88%	2%	6%	3%	1%	0
■ Vol 2023	80%	4%	5%	5%	1%	5%
■ Vol 2020	81%	2%	2%	3%	2%	10%

■ BNSSG ■ NBT Staff ■ Vol 2024 ■ Vol 2023 ■ Vol 2020

## Age

In 2024, 58% of our volunteer work force were aged over 61, and a further 14% are aged between 51-60. The evidence shows that making a contribution to your community in later life has many benefits, including increasing quantity and quality of social connections, enhanced sense of purpose and self-esteem and improved life satisfaction, happiness and wellbeing.<sup>1</sup> We recognise the huge mutual benefit that our volunteers over 50 bring to our patients, and also the positive outcome they can experience from a well-supported volunteer programme. We will continue to provide this volunteer cohort with support and recognition to maintain our retention levels and demonstrate their value.

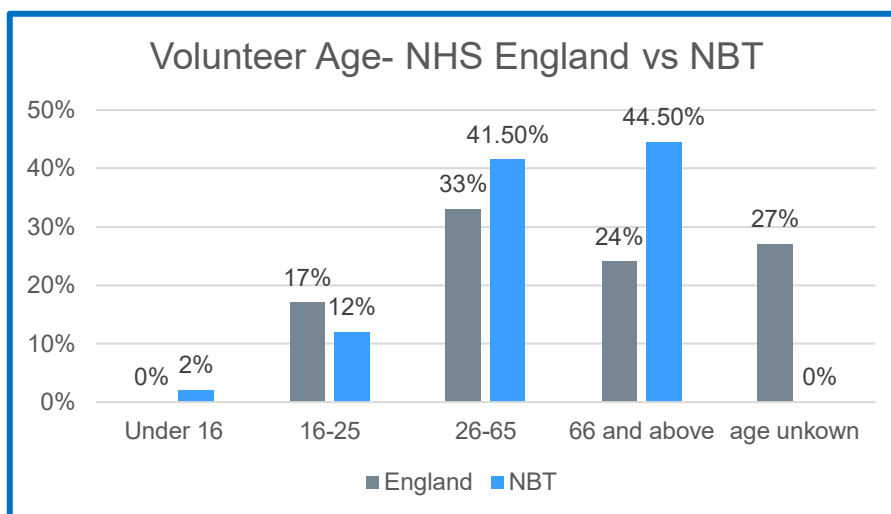


In 2024, we saw an increase of 5% in our volunteers aged between 17-20 years old, compared to 2023, totaling 11% of our volunteers. This has been a result of the promotion of our ward support volunteer role, which has attracted volunteers who are particularly interested in health care careers. We have also maintained connections with SGS College and the NHS Cadets scheme and provided volunteer opportunities for their courses.

The Fresh Arts Musicians have the second highest number of volunteers in the 17-20 years old age bracket and is the only volunteer team that is able to allow musicians under 16's to play in hospital atrium, accompanied by a responsible adult. This has been a unique opportunity to engage with a demographic at this young age and to provide them with an opportunity to build their confidence performing in a public setting and introduce them to the volunteering and hospital sector at a young age.

In comparison to NHS England volunteer workforce data collected from NHS Trusts across England we have 5% fewer volunteers aged between 16-25. The data also shows an +8% and +20.5% in NBT volunteers aged between 16-65 and 66 and above respectively. Currently, the data collection for volunteer age is not mandatory and this has left an anomaly of 27% of volunteer ages unknown across England. Due to this deficit, we will revisit this comparison in April 2026 when NHS England have a complete picture of volunteer data.

<sup>1</sup> K. Jopling & D. Jones, "Age-friendly and inclusive volunteering: Review of community contributions in later life", October 2018.

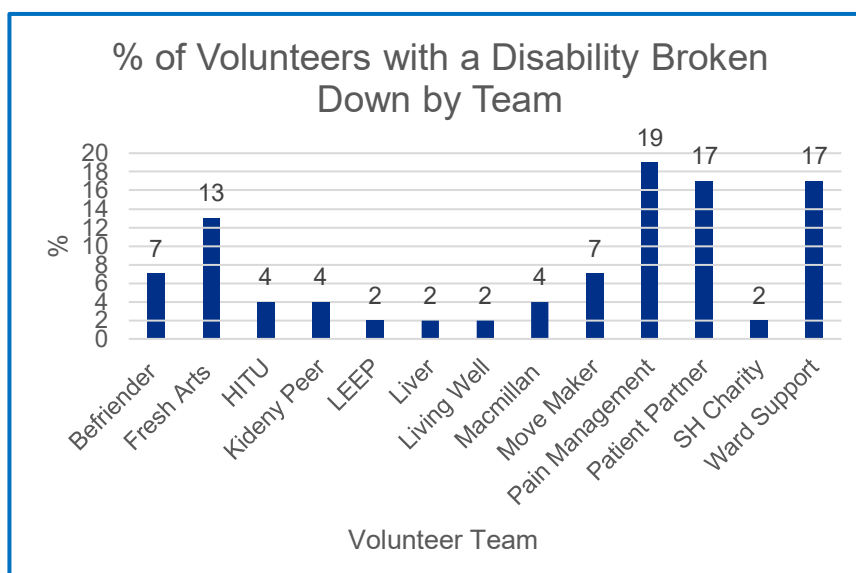


We feel that giving the opportunity to young people to gain experience within a health care setting to further enhance their career pathway into the NHS is vital to become an anchor in our community and support the NBT workforce plan. We therefore look to further increase our number of volunteers aged between 17-30.

## 2.0 Demographic Breakdown per a Volunteer Team 2024

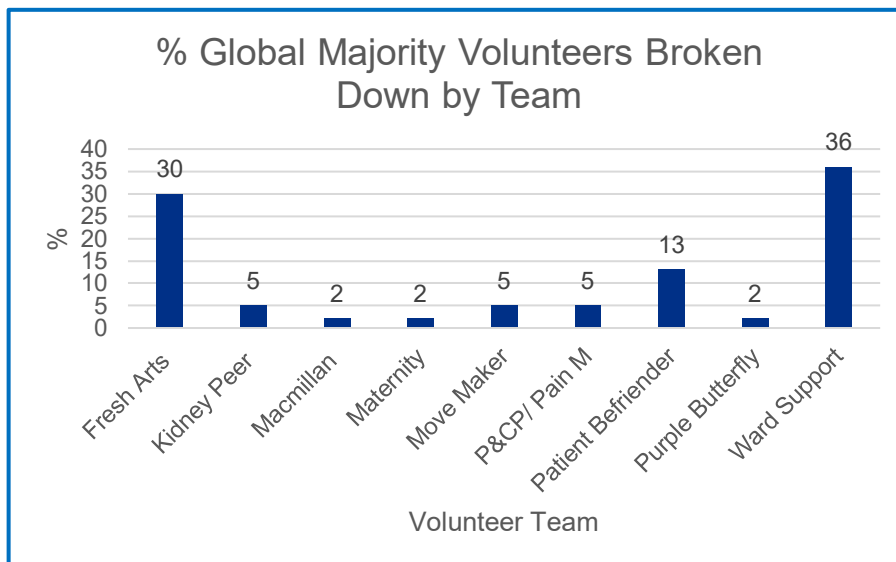
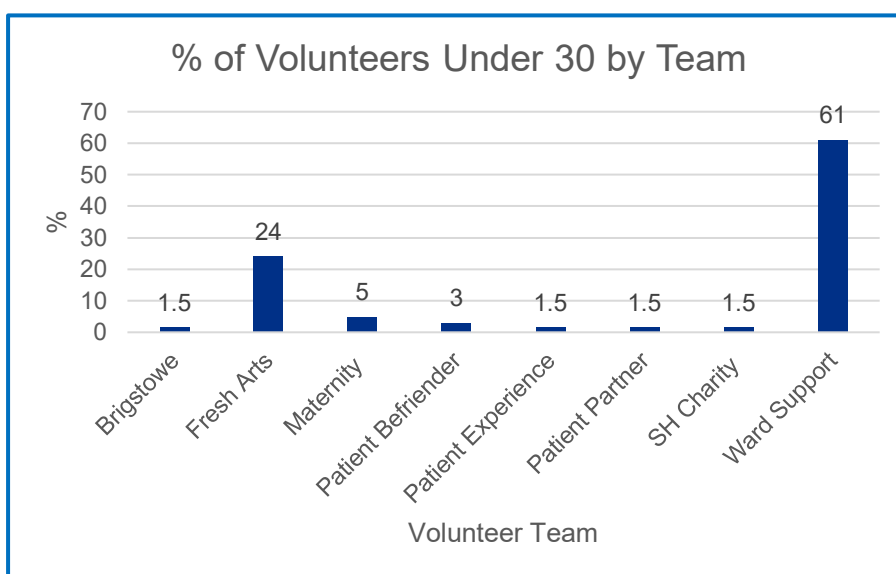
To further understand who is conducting our different volunteer roles, we have broken down the total percentage of our volunteers, in 2024, who are aged under 30, are from a global majority background and have a disability. We have up to 30 different volunteer roles, and the graphs below show only the roles that include representatives from their stated categories.

Our data shows that the majority of volunteers who identify as having a disability are conducting a volunteer role that requires them to have lived patient experience.



Our Ward Support role has attracted the highest number of volunteers under 30, from a global majority background, and with a second highest percentage of our volunteers who have a disability. Secondly our Fresh Arts Musician also have a high percentage across all three demographics. We know our Ward Support role is appealing to students who are looking for work experience within health and social care, and we recognise this role has the largest portion of available vacancies, and therefore the largest volume of newly recruited volunteers.

We need to further understand why the Ward Support and Fresh Arts Musician role is attractive to applicants and how we can adapt our other roles and recruitment process to appeal to a wider audience. We need more detailed feedback to understand what barriers our community face when considering applying for a volunteer role so that we can react and make informed changes. Appendix 2 shows a copy of the North Bristol NHS Trust Volunteer Survey which will be shared within our community as a starting point for gathering feedback about barriers to volunteering with us.



### 3.0 Conclusion

Through reflecting on our volunteer demographic data, we have identified areas of opportunity to increase the number of volunteers aged between 17-30, a larger number from a global majority background and more volunteers who identify as having a disability. We have recognised we need further information to make specific operational changes to our volunteer recruitment and management process, such as feedback from our community about barriers they face when considering volunteering with us. This report has given us a richer understanding of our volunteers and formed a basis for our initial decision making around our strategic approach to diversifying our pool of volunteers.

### Appendix 1- Volunteer Demographic Data Set 2025

<p><b><u>Disability</u></b>  Learning Disability/Difficulty  Long-standing illness  Mental Health Problem  Other  Physical Impairment  Sensory Impairment  Yes - Unspecified  None  Not Disclosed</p>	<p><b><u>Gender</u></b>  Male  Female  Other Term Preferred  Not Disclosed</p>
<p><b><u>Ethnicity</u></b>  White - British  White - Irish  Any other white background  Mixed White and Black Caribbean  Mixed White and Black African  Mixed White and Asian  Any other mixed background  Asian or Asian British - Indian  Asian or Asian British - Pakistani  Asian or Asian British - Bangladeshi  Any other Asian background  Black or Black British - Caribbean  Black or Black British - African  Any other Black background  Chinese  Any other ethnic group  Not Disclosed</p>	<p><b><u>Marital Status</u></b>  Single  Marries  Civil Partnership  Legally Separated  Divorced  Widowed  Other  Not Disclosed</p>
<p><b><u>Religion</u></b>  Atheism  Buddhism  Christianity  Hinduism  Islam  Jainism  Judaism  Sikhism  Other  Not Disclosed</p>	<p><b><u>Sexual orientation</u></b>  Heterosexual or Straight  Gay or Lesbian  Bisexual  Other sexual orientation not listed  Undecided  Not Disclosed</p>
<p><b><u>How did you hear about us</u></b>  NBT Website  NBT Social Media posts  Southmead Hospital Charity Social Media posts  Posters within NBT Hospitals  Word of mouth</p>	

## Appendix 2- North Bristol NHS Trust Volunteer Survey

If you would like this survey in a different format, please get in touch with us on [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) or 0117 414 0110.

### 1. Are you a North Bristol NHS Trust staff member?

Yes	
No	

### 2. Did you know you could volunteer at our hospital?

Yes	
No	

### 3. If yes, how did you hear about our opportunities?

Social media		I was/am a patient	
NBT Website		I have visited the hospital	
Word of Mouth		I work with the hospital	
Other:			

### 4. Have you considered volunteering at our hospital?

Yes	
No	
I am a current NBT volunteer	

### 5. Have you considered volunteering outside of the hospital?

Yes	
No	
I currently volunteer elsewhere	

### 6. If you have any, what do you feel are your barriers to volunteering with us?

Please tick any that apply or use the open text box

I don't want to make an ongoing commitment		I am worried that I wouldn't fit in with the other people who were involved	
I am only interested in short term roles		I have an illness or disability that I feel prevents me from getting involved	
I do other things with my spare time		I don't think my existing skills/ experience could be used	
I have work commitments		I am not confident with computers and the application process is online	
I have study commitments		I am worried about the risks	
I have children and do not feel I have more time to give		I am put off by the recruitment process (e.g. DBS check, references, training)	
I am a Carer and do not feel I have more time to give		I have been put off by negative experiences volunteering in the past	
I'd be worried I haven't got the right skills or experience to help		I am worried I might end up out of pocket (e.g. transport costs to go volunteer)	
English is not my first language. I worry that people might not understand me		I do not think I am available when the volunteer shifts take place	
English is not my first language. I find reading, writing and form filling a challenge.		I do not feel I have a barrier	
Please feel free to share another reason:			

## 7. If you are interested in volunteering with us, what roles would interest you the most?

*Please tick up to three options and/or use the open text box*

Visiting patients to talk, listen, plays games, or read with them.	<input type="checkbox"/>	Offer peer support to patients who have the same diagnosis as you	<input type="checkbox"/>
Supporting with mealtimes on our hospital wards	<input type="checkbox"/>	Providing spiritual/pastoral/religious care to our patients with our chaplaincy team	<input type="checkbox"/>
Greeting our outpatients at check in and helping with way finding	<input type="checkbox"/>	Providing support to our maternity patients	<input type="checkbox"/>
Speaking to inpatients to get feedback on their hospital experience	<input type="checkbox"/>	Serving refreshments within our League of Friends cafés	<input type="checkbox"/>
Sharing your own experience as a patient to improve our services	<input type="checkbox"/>	Fundraising for our hospital charity	<input type="checkbox"/>
Play the piano, or other instrument for the enjoyment of our visitors, staff, and patients	<input type="checkbox"/>	Pushing an activity trolley around the wards to engage patients	<input type="checkbox"/>
Supporting patients to do creative/art activities	<input type="checkbox"/>	Being a community connector, speaking to our local community about volunteer roles and hospital services	<input type="checkbox"/>
Supporting patients to access digital platforms such as their NHS App.	<input type="checkbox"/>	I am not interested in volunteering	<input type="checkbox"/>
I have another area of interest:			

## 8. What would encourage you to volunteer with us?

*Please tick any that apply or use the open text box*

If I could be flexible with the time committed	<input type="checkbox"/>	If the process for getting involved was easier and quicker	<input type="checkbox"/>
If I could be flexible about the way I gave my unpaid time (e.g. do it from home/ adhoc/ at the last minute)	<input type="checkbox"/>	I am disabled. I would need transport provided (e.g. to get to and from the organisation etc.)	<input type="checkbox"/>
If someone asked me to get involved	<input type="checkbox"/>	If I knew it would benefit me in my career/ job prospects	<input type="checkbox"/>
If I knew about what opportunities to help were available	<input type="checkbox"/>	If my employer supported/ encouraged it	<input type="checkbox"/>
If my family/ friends got involved with me	<input type="checkbox"/>	If I knew it would help me improve my skills	<input type="checkbox"/>
If I could meet new people	<input type="checkbox"/>	N/A nothing in particular would encourage me to get involved	<input type="checkbox"/>
If I knew I could get any expenses paid	<input type="checkbox"/>	I don't know	<input type="checkbox"/>
I have another reason:			

## 9. Do you have any other feedback you would like to provide to us today about volunteering opportunities at North Bristol NHS Trust?



## Demographic Information

This section is optional. These answers will not be traced back to you as an individual. The reason we collect this information is to help us understand if there are groups of people who are currently experiencing barriers to accessing our volunteer opportunities.

*Please tick the right-hand box to indicate your answer.*

### Ethnicity

White	British	
	Irish	
	Any other white background	
Mixed	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other mixed background	
Asian/ Asian British	Indian	
	Pakistani	
	Bangladeshi	
	Any other Asian background	
Black/Black British	Caribbean	
	African	
	Any other Black background	
Chinese		
Any other ethnic group		
Prefer not to say		

### Age

< 16 Years	
17 - 21 Years	
22 - 30 Years	
31- 40 Years	
41 - 50 Years	
51 - 64 Years	
65+ Years	
Prefer not to answer	

### Disability

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

Long-standing illness		Yes - Unspecified	
Mental Health Problem		Other	
Sensory Impairment		None	
Physical Impairment		Prefer not to answer	

Do you have a Learning Disability?

Yes		Prefer not to say	
No			



### Religious Belief

Atheism		Jainism	
Buddhism		Judaism	
Christianity		Sikhism	
Hinduism		Other	
Islam		Prefer not to answer	

### Sexual Orientation

Heterosexual or Straight	
Gay	
Lesbian	
Bisexual	
Other sexual orientation not listed	
Undecided	
Prefer Not To Answer	

### Gender

Female	
Male	
Other Term Preferred	
Prefer not to answer	

**Thank you for taking part in our survey.**

If you would like to know more about our volunteer roles and our current opportunities visit our website on: <https://www.nbt.nhs.uk/support-us/volunteering>.

You can get in touch with us via [volunteer.services@nbt.nhs.uk](mailto:volunteer.services@nbt.nhs.uk) or 0117 414 0110.  
 If you would like to access an online version of this survey, please use the link or QR code below:

**<http://ratenhs.uk/z5TQPN>**



## Equality Impact Assessment (EIA)

Other documents required to complete the Equality Impact Assessment:

- **Equality Impact Assessment Guidance**
- **Equality Impact Assessment Resources**

**Please ensure you read the guidance and resources in full before attempting to complete this template**

<b>Title of Proposal:</b> Volunteer Services Strategic Plan 2025-2028				<b>Date:</b> 3/3/2025
<input type="checkbox"/> Policy	<input checked="" type="checkbox"/> Strategy	<input type="checkbox"/> Service	<input type="checkbox"/> Function	<input type="checkbox"/> Other (Please State)
<b>Has an EIA been previously undertaken?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>Stage of Service</b>	Development <input type="checkbox"/>	Implementation <input type="checkbox"/>	Review <input checked="" type="checkbox"/>	
<b>Lead Person(s) Completing This Assessment:</b> Kathryn Tudor-Thomas				
<b>Lead Person Job Title(s) and Service Area:</b> Volunteer Service Manager, Volunteer Services, Patient Experience				

### Step 1: Outline

#### 1.1 Briefly Describe the Proposal

Give a brief description of the context, purpose, aims, and objectives of the proposal. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EIA (e.g. proceed with the policy / proposal or not, to publish the employee handbook etc).

Our established team of over 400 volunteers donate their time to improve the experience for our patients, staff, and visitors across our hospital sites. Our volunteers support our patients in unique ways and support our staff to deliver patient-centred care.

Our previous strategic plan (2021-2024) focused on making operational improvements to help recover the service following the Covid-19 pandemic. The purpose of our new strategic plan puts inclusive practices, continuous learning, and a welcoming culture at the heart of all we do. We want to elevate our service to diversify our pool of volunteers, break down barriers to volunteering, further improve the experience for our patients and volunteers, and bring our service into a modern era where our systems are fit for purpose.

We are focusing on four key objectives to transform our service from the start of the volunteer journey to the patients who are at the heart of our service:

- Objective one: Foster a culture of inclusivity throughout our service, with the aim to break down barriers to volunteering with us, and in turn diversify our pool of volunteers.
- Objective two: Improve the experience for our patients through enhancing our existing volunteer offer.
- Objective three: Develop the volunteer journey to provide an individualised and supportive experience with an open and welcoming culture.
- Objective four: Modernise our systems to manage our data, more widely capture our impact, and embrace the Group Model.

Our service recognises the importance and value of a diverse volunteer workforce. To achieve this, we need to learn and listen to our community to understand the barriers to volunteering and how we can improve our recruitment practices, culture and support. We aim for an increase in the number of volunteers aged between 17-30, a larger number from a global majority background and more volunteers who identify as having a disability. This is our priority commitment because it will embed a new way of working which will influence all our other service actions, we know this will take time and commitment to achieve properly.

We recognise that we do not fully understand yet all the equality impacts our service might have for our volunteers and patients. With that in mind we have created a detailed 3-year action plan to accompany our objectives. We will approach our objectives in an authentic way that does not assign specific KPI's which risk tokenism and volunteers feeling they have been targeted to fill a quota.

The key benefit of achieving this strategic plan will create a more accessible and supportive volunteer service, which has made proactive changes to reach further into our local community to diversify our pool of volunteers, and in turn support a wider variety of our patients. Our systems will be fit for purpose, and robust management of our volunteer data will result in a more efficient understanding of our volunteer demographics and impact.

This evolution of our service will impact volunteers, patients, visitors and staff. Through completing this EIA we intend to proceed with the strategic plan, and to review the EIA annually to ensure we are in keeping with its core purpose.

Please give details of any evidence, research, or data used to support your work, e.g. workforce data, meeting papers, etc below:

To support the development of the strategic plan we wrote a covering report which displays an in depth break down and cross section of our volunteer demographics by year, team, and in comparison, to NHS England data, our NBT staff workforce and BNSSG population (2021 census). This has given us a richer understanding of our volunteer teams and formed a basis for our initial decision making around our approach to diversifying our pool of volunteers.

### **Volunteer demographic data**

In June 2024 we collated and reviewed the volunteer demographics of 366 of our active volunteers. We were also able to cross reference this data with the same gathered in February 2020 and February 2023. The demographic data showed us a basic overview of:

- Gender
- Disability
- Age
- Ethnicity

We have further added more data sets to our volunteer demographics, and we now collect detailed demographic information inline with the NHS England Data Collection requirement. This includes additional themes:

- Religion
- Sexual Orientation
- Marital Status
- Specific Disability

In June 2025 we will have access to NHS England EDI Volunteer Data Collection results, to further use as a benchmark for our service.

### **Research**

We read the following research report: [Time Well Spent 2023: Volunteering among the global majority](#), published by the National Council for Voluntary Organisations (NCVO). The research showed us that “a culture of trust and respect, recognition, and a sense of belonging are particularly important to people from the global majority. These factors influence overall satisfaction with volunteering.” To help mitigate unconscious bias and groupthink, we set an aim to have representation on our interview panel from a volunteer or staff member who can act as an ambassador. This individual may be from a global majority background, have a disability, or other protected characteristic.

## Strategy

To ensure our strategic plan was playing a role within our wider Trust strategic direction we read the following material:

- Joint Clinical Strategy 2024-2027
- Patient First Strategy and approach
- Patient and Carer Experience Strategy 2023-2026
- Mental Health Strategy 2024-2028
- UHBW Volunteering Strategy 2023-2026
- NBT 3-year EDI Plan
- Spiritual Pastoral and Religious Care Strategy Plan 2023-2027
- CQC Quality Statements

As a result, our four objectives focus on the following Trust improvement priorities and objectives:

- Anchor in our Community
- Outstanding Patient Experience
- Proud to Belong
- Unlocking a Better Future

Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal.

Our strategic plan has been designed through conversations with staff, volunteers, and voluntary sector partners. It has also been influenced by the above-mentioned strategies, and our internal recruitment audit recommendations. We shared an overview of our strategic plan with the following groups for feedback:

- Dementia Strategy Group
- Patient and Carer Experience Group
- Carer Strategy Meeting
- Patient and Carer Partnership Group
- Divisional Patient Experience Group

All feedback was welcomed, and no significant impact or major changes have been identified that would impact patients, carers or members of the public.

## Step 2: Impact

### 2.1 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker - references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3.

Positive Impact				
<input checked="" type="checkbox"/> Sex	<input checked="" type="checkbox"/> Race	<input checked="" type="checkbox"/> Disability	<input checked="" type="checkbox"/> Religion & Belief	<input checked="" type="checkbox"/> Sexual Orientation
<input checked="" type="checkbox"/> Age	<input checked="" type="checkbox"/> Pregnancy & Maternity	<input checked="" type="checkbox"/> Marriage & Civil Partnership	<input checked="" type="checkbox"/> Gender Reassignment	<input checked="" type="checkbox"/> Other health inequality (please state below)
<p>Provide a narrative about the benefits, including benefits to any of the protected characteristic groups, plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:</p> <p>The following points below are taken from the 3-year action plan. Demonstrating how our EDI priorities are intrinsically linked to our planned actions.</p> <p><b>Intersectional Impact</b></p> <ul style="list-style-type: none"> <li>As a staff team, it is important that we are all open to genuinely understanding the benefits of a diverse volunteer team and the value this brings to our patients, visitors, and staff. Even if something has worked well before, we understand that it might not be the right process for us now. It is important for us to recognise our bias's, embrace and be open to change, and continuous learning. We will ensure meaningful, up to date, Equality, Diversity, and Inclusion training, exploring scenarios from our recruitment practices and recognising where we can improve.</li> </ul>				

- To help mitigate unconscious bias and groupthink, we will strive to have representation on our interview panel from a volunteer or staff member who can act as an ambassador. This individual may be from a global majority background, have a disability, or other protected characteristic.
- The locations in which we promote our volunteering opportunities will be integral to reaching a wider audience. We will work closely with the central comms and Talent teams to promote our roles, and we will look at ways to be creative, accessible, and inclusive with our messaging and imagery to attract a wide range of volunteers.
- We need to further understand the barriers people may face when hoping to volunteer with us. We will ask our community, in a variety of ways, what their barriers are to volunteering through a short accessible survey and qualitative conversations.
- Our patients are at the heart of everything we do, and our volunteers play an important role in gathering impact and patient stories which will inform broader changes across the hospital, with the potential to reduce health inequalities. This gathering of patient feedback not only meets the CQC statement that NBT “make it easy for people to share feedback and ideas”, but it is also a key mechanism to measure the outcome of our Trust objective to achieve an outstanding patient experience.
- We will provide more opportunities for our volunteers to express their feedback and ideas. We want our volunteers to feel connected with each other, understand what the wider volunteer and Patient Experience team are accomplishing and be able to easily access wellbeing support. We will commit to conducting an annual volunteer survey to provide the volunteers with an opportunity to feedback anonymously about their volunteer journey. Furthermore, we will explore additional feedback and support opportunities, such as formalised supervision sessions and volunteer peer support.
- We hope to see a correlation between the increase in diversity within our volunteer team and the reach our volunteer roles have with a broader range of patients. For example, a Patient Befriender volunteer may be able to speak to a patient in their native language.

### **Sex/Race/Disability/Sexual Orientation/Gender Reassignment**

- As stated above, we are not assigning specific KPI’s to the increase of our pool of volunteers. Through our change in culture and approach to inclusion we aim for an increase in the number of volunteers aged between 17-30, a larger number from a global majority background and more volunteers who identify as having a disability.

## Religion & Belief

- We work alongside and collaboratively with our colleagues in Spiritual, Pastoral and Religious Care. We aim to support the recruitment of more volunteer chaplains from a variety of faiths or none, exploring joint recruitment and training with UHBW.

## Age

- We aim to grow our pool of young adult volunteers, including our NHS Cadets, to support the next generation of the NHS workforce. To do this we want to forge greater relationships with our local colleges and universities, and stronger links with our apprenticeship and work experience programmes. We want to work towards seeing a clear volunteer to career progression for our volunteers who are looking for health care opportunities.
- We will provide information on volunteer opportunities to the Community Officer (Dre Williams) who is reaching out to people to provide employment skills. We will work together to sign post members of our community to volunteer opportunities.
- We will continue to update our social media platforms and website to highlight the support that is available for our volunteers if they join our team, using positive language around training, highlighting out of pocket expenses and transferable skills to attract a non-clinical audience.

## Disability

- We are aware that through expanding our pool of younger age volunteers, we may see an increase in volunteers who are neuro divergent. We will utilise the existing NBT guidelines, and toolkits to make reasonable adjustments. We will adopt the Social Model of Disability rather than the Medical Model, to ensure our volunteers feel welcome and holistically supported. We will seek advice from the Equality Officer to offer further bespoke support where necessary.

## Pregnancy and Maternity

- We will continue with the recruitment and placement of volunteers within our Maternity Ward Support role. Providing complimentary support to improve the patient experience within this department.

## Other Health Inequalities

- We will increase the number of volunteers identifying with specific health conditions (for example diabetes, mental health condition, and cancer) and actively recruiting them to our Patient and Carer Partnership.



- We will introduce a diverse range of trained Patient Experience Volunteers to collect feedback and patient stories from a range of patients representing the nine protected characteristics of the Equality Act as well as a range of conditions, including patients with mental health conditions and learning Disabilities.
- We will work with the Associate Chief Nursing Officer for MH, LD & Neurodiversity to resource relevant training for our volunteers to appropriate support our patients.
- We will look at the feasibility of a free activity trolley in Elgar House to provide dementia patients with creative materials and how this can be expanded throughout the hospital site.

**Negative Impact**

<input type="checkbox"/> Sex	<input type="checkbox"/> Race	<input checked="" type="checkbox"/> Disability	<input type="checkbox"/> Religion & Belief	<input type="checkbox"/> Sexual Orientation
<input checked="" type="checkbox"/> Age	<input type="checkbox"/> Pregnancy & Maternity	<input type="checkbox"/> Marriage and Civil Partnership	<input type="checkbox"/> Gender Reassignment	<input type="checkbox"/> Other health inequality (please state below)

Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

**Intersectional**

- The NHS Volunteer recruitment process follows a robust and structured approach to ensure that we are upholding our duty of care to our patients by conducting a safe recruitment process. Conducting a DBS check, two reference checks, an Occupational Health review and a suite of mandatory training can be a long process which some applicants find demanding and off putting. This can be especially hard for volunteers who are refugees or asylum seekers, those where English is a second language, or those who have a low reading age  
We are committed to ensuring our process is safe, however we recognise that we can learn from other Trusts to understand how they may have streamlined their recruitment and training process to make the journey smoother and our training more accessible to volunteers.

**Disability**

- All our staff will attend bespoke EDI training relating to volunteer recruitment and will continue understanding the importance of reasonable adjustments. We recognise that it may not be possible to adapt all our roles to be able to suitably support people with certain disabilities, especially those that may need one to one support. We will always try our very best to support any reasonable adjustments and seek alternative volunteer placements where possible.

### Age

- Our recruitment and training process is predominantly through a digital platform. Some of this is out of our control due to being led by external services, for example the DBS and Occupational Health Review can only be conducted online with an email address. We recognise this is a digital exclusion barrier for those that do not have access to a computer, or do not feel confident using IT. We have identified ways to support this group of people, by organising paper based/in person training and supporting with the setting up of an email address they can access on site.

(You can share further details and mitigations below in section 2.2)

### No Effect

Your policy might not have a positive or negative impact, or it might maintain a status quo - complete this section if 'not applicable'

## 2.2 Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the 'playing field' for all people.

Protected Characteristic(s)	Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion)	Identify any mitigations that would help to reduce or eliminate the negative impact
Intersectional	Barrier to volunteering for those who are asylum seekers, refugees or those that do not have references or a home address. This is due to the robust NHS volunteer recruitment guidelines that require a DBS check, two	-We will seek advice from local refugee and asylum seeker charities and our Employment Services team to support the volunteer through the recruitment process.

	reference checks, an Occupational Health review and a suite of mandatory training.	<ul style="list-style-type: none"> <li>-We will use our approved reduced reference flowchart to support those who do not meet the standard reference requirement.</li> <li>-We will offer the option of the applicant to apply for a volunteer role that does not require a DBS check.</li> <li>-We will seek advice from the Learning Team about how to provide our training materials in different languages.</li> <li>-We will understand what other Trusts have implemented to streamline their volunteer recruitment process.</li> </ul>
Disability	Being unable to support all volunteer reasonable adjustments. E.g. those who require full time one-to-one support to conduct their volunteer role.	<ul style="list-style-type: none"> <li>-Any volunteer with a disability will have the option to be referred to Occupational Health for advice on support and reasonable adjustments.</li> <li>-All adjustments that are able to be accommodated will be put in place.</li> <li>-If adjustments are not feasible, alternative appropriate volunteer roles will be offered.</li> <li>-If there are no roles within the Trust, sign posting to external volunteer opportunities will take place.</li> <li>-We will consider that some volunteers, e.g. volunteers with neurodiversity, may not wish to be referred to Occupational Health and would benefit from an informal support conversation to express the adjustments they require.</li> </ul>
Age	Digital exclusion through predominantly online access to the recruitment and training process to become a volunteer.	<ul style="list-style-type: none"> <li>-In person support for the recruitment process will be provided to those that do not have access to a computer at home.</li> <li>-A paper application form can be provided to applicants, however this will be uploaded onto the Trac recruitment system for processing due to audit purposes.</li> <li>-Providing training materials will be provided in a paper format.</li> </ul>

		-The availability of in-person training will be an option to volunteers in the future.
--	--	--

### 2.3 Outline any benefits of the proposal for people based on their protected or other relevant characteristics?

Outline potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our **Public Sector Equality Duty** to:

<b>To eliminating discrimination, harassment, and victimisation</b>	Positive <input checked="" type="checkbox"/>
	Negative <input type="checkbox"/>
	No effect <input type="checkbox"/>
<p>Please describe:</p> <p>To help mitigate unconscious bias and groupthink during our volunteer interview process, we have set an aim to have representation on our interview panel from a volunteer or staff member who can act as an ambassador. This individual may be from a global majority background, have a disability, or other protected characteristic. This action alongside our aim for bespoke EDI training for our staff team aims to ensure that our recruitment process is fair and free from unconscious bias.</p> <p>We will record our volunteer demographic data in more detail than before, allowing us the opportunity to monitor applicant progress by protected characteristic to ensure we are picking up recruitment barriers early.</p> <p>We will conduct an annual volunteer survey, and other informal feedback opportunities, to gather good quality feedback about the volunteer experience.</p>	

<b>To advance equality of opportunity between people who share a protected characteristic and those who do not</b>	Positive <input checked="" type="checkbox"/>
	Negative <input type="checkbox"/>
	No effect <input type="checkbox"/>
<p>Please describe:</p> <p>We plan to listen to a wide range of representatives within our local community to understand the barriers they may face to our volunteer recruitment process. We will respond to this feedback by implementing adjustments to be able to support and encourage volunteers with a protected characteristic to apply and be successful in their volunteer role.</p>	

<b>To foster good relations between people who share a protected characteristic and those who do not</b>	Positive <input checked="" type="checkbox"/>
	Negative <input type="checkbox"/>
	No effect <input type="checkbox"/>
<p>Please describe:</p> <p>We will increase the number of volunteers identifying with specific health conditions (for example diabetes, mental health condition, and cancer) and actively recruiting them to our Patient and Carer Partnership.</p> <p>We will also introduce a diverse range of trained Patient Experience Volunteers to collect feedback and patient stories from a range of patients representing the nine protected characteristics of the Equality Act as well as a range of conditions, including patients with mental health conditions and learning Disabilities.</p> <p>These two roles will be an opportunity for volunteers and patients with a protected characteristic to have a platform for their voice to be heard, to shape future care, and inspire a better understanding between people who do not share their characteristic.</p>	

## Step 3: Plan

### 3.1 What actions will you take to mitigate the negative impact outlined above?

Action	Timeframe	Success Measure	Lead
To include a volunteer demographic summary within our quarterly Volunteer Services report to recognise opportunities and demonstrate our commitment to diversifying our pool of volunteers.	Quarterly	Each quarterly report from April 2025 to include demographic volunteer summary.	Bwalya Treasure (year 1)
Annual Volunteer Feedback Survey and Action Plan	Annually	Distribution of annual volunteer survey, analysis and action plan	Bwalya Treasure (year 1) Kat Tudor-Thomas (year 2)

### 3.2 How and when will you review the action plan (include specific dates)?

This EIA and the associated action plans will be reviewed annually, from May 2026.

## Step 4: Impact

### 4.1 What are the main conclusions of this Equality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EIA has informed, influenced, or changed the proposal and include a recommendation for the decision maker.

This EIA has supported the formation of our strategic action plan, which considers in detail a range of positive actions to improve the engagement of our service with volunteers and patients from groups with protected characteristics. It has also highlighted areas of opportunity and improvement in regards to our volunteer recruitment and placement process.



Select a recommended course of action:	
<b>Outcome 1:</b> Proceed - No potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified.	<input checked="" type="checkbox"/>
<b>Outcome 2:</b> Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity, and fostering good relations or breach of human rights articles.	<input type="checkbox"/>
<b>Outcome 3:</b> Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out).	<input type="checkbox"/>
<b>Outcome 4:</b> Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified.	<input type="checkbox"/>

## Step 5: Review

All Equality Impact Assessments should be reviewed internally and obtain director level sign off to show an organisational commitment.

<b>Reviewer's Feedback - This document should be reviewed by an Equality Officer. Send to <a href="mailto:Inclusion@nbt.nhs.uk">Inclusion@nbt.nhs.uk</a></b>	
<b>Equality Officer Name:</b> Caroline Hartley, Associate Director of Culture and Staff Experience	<b>Director Name:</b> Paul Cresswell, Director of Quality Governance
<b>Equality and Inclusion Team Signature:</b> C. Hartley	<b>Director Signature:</b> P. Cresswell
<b>Date:</b> 10/3/2025	<b>Date:</b> 10/3/2025

# Volunteer Services



Strategic Plan 2025-2028

# Our Previous Strategic Plan

We made operational improvements to recover from the impact of the Covid-19 pandemic. At the forefront of our ways of working was keeping our volunteers and patients safe.

## Key successes:

- Centralised Recruitment Process
- Bristol Sight Loss Council Training
- New Volunteer Handbook & Comms
- SGS College & NHS Cadets
- New Volunteer Roles

## Looking forward

- Volunteer Feedback Survey
- We will broaden our ambition to radically change our culture, to understand the barriers to volunteering for those with different protected characteristics.



# Our Vision

**“To deliver an inclusive, supportive, and safe Volunteer Service, driven by continuous learning and our commitment to put the patient experience at the heart of everything we do.”**





# Objectives

We will;

## Objective one:

Foster a culture of inclusivity throughout our service, with the aim to break down barriers to volunteering with us, and in turn diversify our pool of volunteers.



## Objective two:

Improve the experience for our patients through enhancing our existing volunteer offer.



## Objective three:

Develop the volunteer journey to provide an individualised and supportive experience with an open and welcoming culture.



## Objective four:

Modernise our systems to manage our data, more widely capture our impact, and embrace the Group Model.



# Foster a Culture of Inclusivity



1

**Forging strong cross-departmental relationships & utilising their community links**

1

**Ensuring our recruitment staff are trained, and our interview panel is diverse**

2

**Volunteer role promotion opportunities**

4

**Reviewing our recruitment process**

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Patient First Update		
<b>Report Author:</b>	Helen Gilbert, Director of Improvement		
<b>Report Sponsor:</b>	Glyn Howells, Hospital Managing Director		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		<b>YES</b>	
	Annual update on progress with <ul style="list-style-type: none"> <li>the Trust Improvement Priorities (Breakthrough Objectives)</li> <li>implementation of the Patient First Approach</li> </ul>		
<b>Key Points to Note</b> ( <i>Including any previous decisions taken</i> )			
<ul style="list-style-type: none"> <li>Steady progress with capability building with the majority of those trained learning the A3 problem solving approach</li> </ul> Progress with the Breakthrough Objectives <ul style="list-style-type: none"> <li>Two of the eight with sustained improvement</li> <li>Three of the eight with no material change</li> <li>One of the eight in a deteriorating position</li> <li>Two of the eight showing signs of improvement not yet sustained</li> </ul> Reframing the Patient First Offer <ul style="list-style-type: none"> <li>Early support from two divisions for moving to a business partnering model</li> </ul>			
<b>Strategic and Group Model Alignment</b>			
The current portfolio and progress with our Improvement Priorities is informing Patient First alignment discussions for the Group Model			
<b>Risks and Opportunities</b>			
Active opportunity to further review and reframe how the Patient First approach is implemented at NBT and in light of the Group Model			
<b>Recommendation</b>			
This report is for Discussion Board is asked to discuss progress with the Breakthrough Objectives and note the current status of capability building and plans for developing this with the divisions			
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>			
Patient First Steering Group		Wednesday 19 <sup>th</sup> March 2025	
<b>Appendices:</b>	Appendix: Patient First Improvement Priorities: Highlight Reports		

**1. Purpose**

- 1.1 This report is providing a high level overview of progress with the critical components of our Patient First Approach

**2. Background**

- 2.1 NBT is currently two years into the formal implementation of the Patient First approach

**3. Patient First Update Presentation**

- 3.1 The presentation has been created in three discrete sections: 1: Progress with training implementation 2: Progress with delivering material and sustainable improvements to the Trust Improvement Priorities and an early overview of developing capability building directly within two divisions.

**4. Summary and Recommendations**

Board is asked to discuss progress with the Breakthrough Objectives and note the current status of capability building and plans for developing this with the divisions.



# Trust Board Patient First Update

Position as at end February 2025



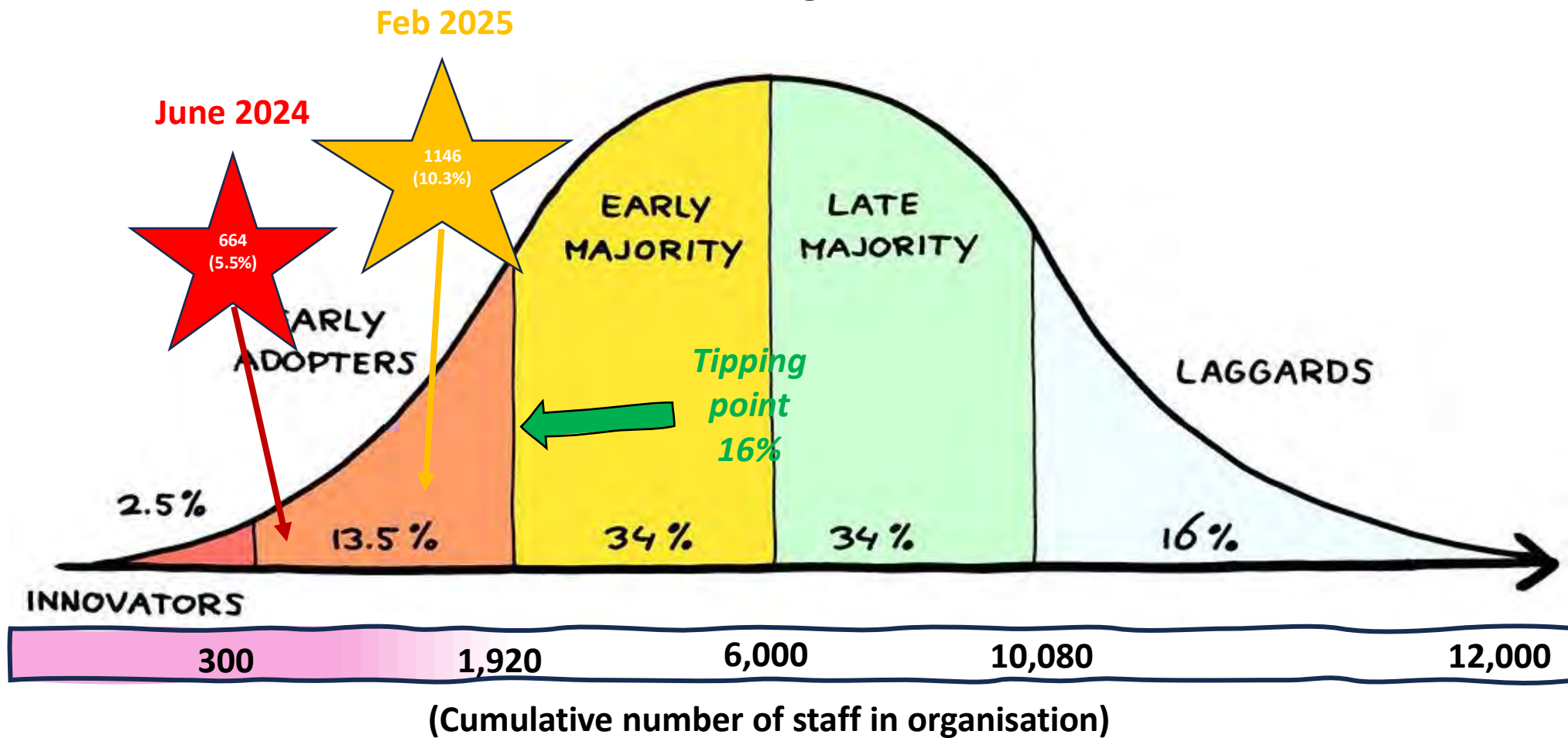
# OUR CAPABILITY BUILDING PROGRAMME



# Progress

This represents anyone who is currently participating or has completed Patient First Training

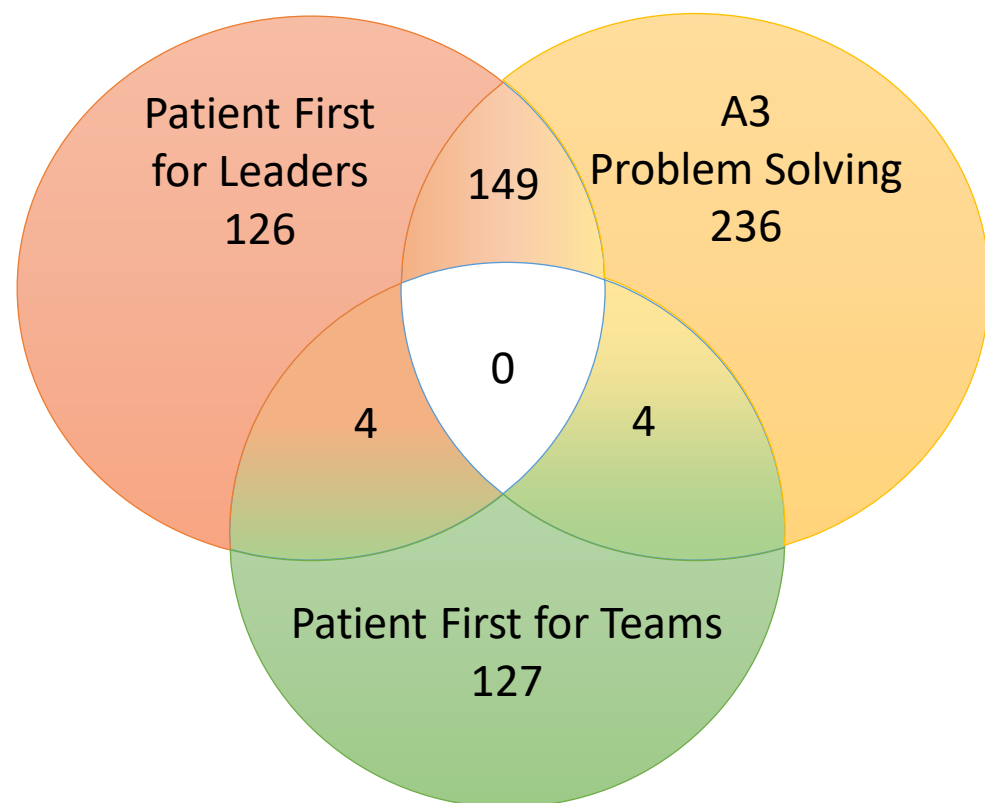
Rogers Everett, M., 1995. Diffusion of innovations New York, 12.



*\*this does not include NBT Extra bank staff (10 NBText staff in progress)*

# Completed Training – Breakdown

This represents anyone who has fully completed Patient First Training



**NEW: Divisional Reporting**  
**Launched February 2025**






**People v Course - Progress**  
**Team v Tool – Progress**



# PROGRESS ON OUR IMPROVEMENT PRIORITIES



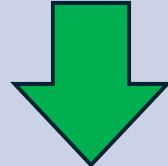




# OVERVIEW Breakthrough Objectives

Improvement Priorities	11. Patient Vision	Breakthrough Objective	Overall Trust Performance
<p><b>PATIENT</b></p> <p><b>Outstanding Patient Experience</b></p> <p>Steve Hams</p>	<p>We consistently deliver person centred care &amp; ensure we make every contact and interaction count. We get it right first time so that we reduce unwarranted variation in experience, whilst respecting the value of patient time</p>	<p><b>PATIENT EXPERIENCE:</b> Improving FFT 'positive' percentage (Target variation by Division/Service)</p> <p><i>KPI UNDER REVIEW FOR 2025/26</i></p>	 <p><b>Within normal variation</b> <b>No material change</b></p>
<p><b>HIGH QUALITY CARE</b></p> <p><b>Better by Design</b></p> <p>Nick Smith</p>	<p>Our patients access timely, safe, and effective care with the aim of minimising patient harm or poor experience as a result</p>	<p><b>TIMELY CANCER TREATMENT</b></p> <p>70% of patients will receive treatment for cancer in 62 days</p>	 <p><b>Dec 2024 73.38%</b></p>
	<p>Our patients access timely, safe, and effective care with the aim of minimising patient harm or poor experience as a result</p>	<p><b>AMBULANCE HANDOVER</b> (Triustwide Flow Challenge)</p> <p>Maintain best weekly delivered position between April 2021 and August 2022</p> <p>141 hrs (w/c 29th Aug 2022)</p>	 <p><b>Feb 2025 404hrs per week avg</b></p>
<p><b>INNOVATE TO IMPROVE</b></p> <p><b>Unlocking a better future</b></p> <p>Tim Whittlestone</p>	<p>We are driven by curiosity; undertake research and implement innovative solutions to improve patient care by enabling all our people and patients to make positive changes</p>	<p><b>STAFF MAKING IMPROVEMENTS</b></p> <p>Increase number of staff able to make improvements in their areas to be 1% point above the benchmark average in 2024 (57% based on 2023 staff survey results)</p>	  <p><b>2024/25 58.4%</b></p>

# OVERVIEW

## Breakthrough Objectives





Improvement Priorities	Vision	Breakthrough Objective	Overall Trust Performance
<p><b>SUSTAINABILITY</b></p> <p>Making best use of our limited resources</p> <p>Elizabeth Poskitt</p>	<p>Through delivering outstanding healthcare sustainably we will release resources to invest in improving patient care</p>	<p><b>COST IMPROVEMENT PROGRAMME</b></p> <p>Deliver the planned levels of recurrent savings in 2025/26</p>	 <p>Feb 2025 £22.2m/£28m</p>
<p><b>PEOPLE</b></p> <p>Proud to belong</p> <p>Peter Mitchell</p>	<p>Our exceptional people deliver outstanding patient care and experience</p>	<p>Staff turnover sustained at 11.9%</p>	  <p>Jan 2025 11.7%</p>
<p><b>COMMITMENT TO OUR COMMUNITY</b></p> <p>In, and for, our community</p> <p>Peter Mitchell</p>	<p>We will improve opportunities that help reduce inequalities and improve health outcomes</p>	<p>Reduce disparity ratio to 1:25 or better</p>	 <p>Jan 2025 1.63</p>
		<p>38% employment from our most socio-economically challenged areas</p>	 <p>Within normal variation No material change</p>

# PATIENT FIRST FOR TEAMS OUR CONTRIBUTION









# OVERVIEW Breakthrough Objectives

Improvement Priorities	Breakthrough Objective Update	Overall Trust Performance	Patient First Interventions
<p><b>PATIENT</b></p> <p><b>Outstanding Patient Experience</b></p> <p>Steve Hams</p>	<p><b>PATIENT EXPERIENCE:</b> Improving FFT 'positive' percentage (Target variation by Division/Service)</p> <p><i>KPI UNDER REVIEW FOR 2025/26</i></p>		<p><b>MEDICINE: Frailty Enablement EEU</b> Reduction in complaints where the theme is poor communication</p> <p><b>NMSK/CCS: Orthopaedic OP: Fracture Clinic</b> Reduction in patients sent inappropriately to Fracture Clinic</p>
<p><b>HIGH QUALITY CARE</b></p> <p><b>Better by Design</b></p> <p>Nick Smith</p>	<p><b>TIMELY CANCER TREATMENT</b></p> <p>70% of patients will receive treatment for cancer in 62 days</p>		<p><b>ASCR: DMT: Performance Reporting</b> Transitioned to an SPC driven reporting culture for process step reporting on Cancer</p>
	<p><b>AMBULANCE HANDOVER</b> (Trustwide Flow Challenge)</p> <p>Maintain best weekly delivered position between April 2021 and August 2022 141 hrs (w/c 29th Aug 2022)</p>		<p><b>MEDICINE: Frailty Enablement: Ward 10a</b> Reduction in LOS</p> <p><b>MEDICINE: Respiratory Medicine: Ward 28a</b> Reduction in medication errors</p> <p><b>NMSK: Orthopaedics OP: Ward 7b</b> Increase in therapy contacts, reduction in LOS &amp; Increase in no. of discharges</p>
<p><b>INNOVATE TO IMPROVE</b></p> <p><b>Unlocking a better future</b></p> <p>Tim Whittlestone</p>	<p><b>STAFF MAKING IMPROVEMENTS</b></p> <p>Increase number of staff able to make improvements in their areas to be 1% point above the benchmark average in 2024 (57% based on 2023 staff survey results)</p>		<p><b>CORPORATE: PATIENT FIRST PROGRAMME</b> Transitioned to an SPC driven reporting culture for process step reporting on Cancer</p> <p>2024: 58.4% of staff able to make improvements in their work area</p>

# OVERVIEW

## Breakthrough Objectives

Improvement Priorities	Breakthrough Objective	Overall Trust Performance	Patient First Interventions
<b>SUSTAINABILITY</b> Making best use of our limited resources Elizabeth Poskitt	<b>COST IMPROVEMENT PROGRAMME</b> Deliver the planned levels of recurrent savings in 2025/26		<b>CORE CLINICAL SERVICES: Pharmacy</b> Reduction in medicines wastage (£s and volume)
			<b>NMSK: BCE: Wheelchair Services</b> Increase in clinical productivity Reduction in staff time to locate equipment
			<b>CORPORATE SERVICES: Operations: IDS</b> Increase staff productivity directly impacting discharge co-ordination
<b>PEOPLE</b> Proud to belong Peter Mitchell	Staff turnover sustained at 11.9%		<b>MEDICINE: Frailty Enablement: Ward 10a</b> Structured succession planning to reduce turnover at Band 5 RN
<b>COMMITMENT TO OUR COMMUNITY</b> In, and for, our community Peter Mitchell	Reduce disparity ratio to 1:25 or better		
	38% employment from our most socio-economically challenged areas		<b>CORPORATE SERVICES: Operations: Patient First Improvement Team</b> Band 3 Team Administrator appointed from Community Pipeline

# REFRAMING OUR PATIENT FIRST OFFER



# Core Clinical Services: PILOT

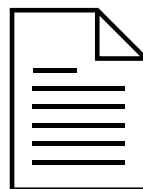


Strategic connectivity in **Centralised Outpatients**

1) An area in which there is already appetite for and evidence of improvement work

- Aligning improvement work with divisional priorities and supporting
- An injection of resource to propel and foster a culture of continuous improvement
- Empower staff with a clear understanding of how their daily work contributes to the divisional and trust wide agenda and the tools to turn the dial on these key metrics.

Print off CMS onto Big Wall in Central Outpatients

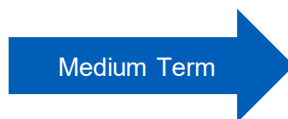


A3 in **Imaging**

2) An area with ownership of a key strategic priority, already well engaged with the methodology

- In depth coaching through the A3 process
- Additional resource to bolster the project team and increase pace of progress

A3 focus on National Guideline Reporting TAT specifically for Urgent outpatient GP 3 day cancer TAT reporting and secondly non-urgent GP 28 day TAT reporting

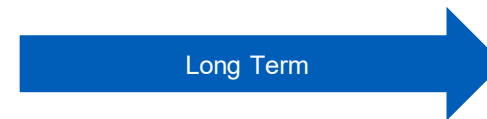


A3 in **Pathology**

3) An area with ownership of a key strategic priority, already well engaged with the methodology

- In depth coaching through the A3 process to grow confidence in the methodology
- Additional resource to bolster the project team and increase pace of progress
- Build confidence in the A3 process and problem-solving tools within it while propelling forward a key piece of work within the division.

A3 focus on Path Lab workflow streams to aid with backlog



**Current 2025 Proposal**

**NBTCARES**

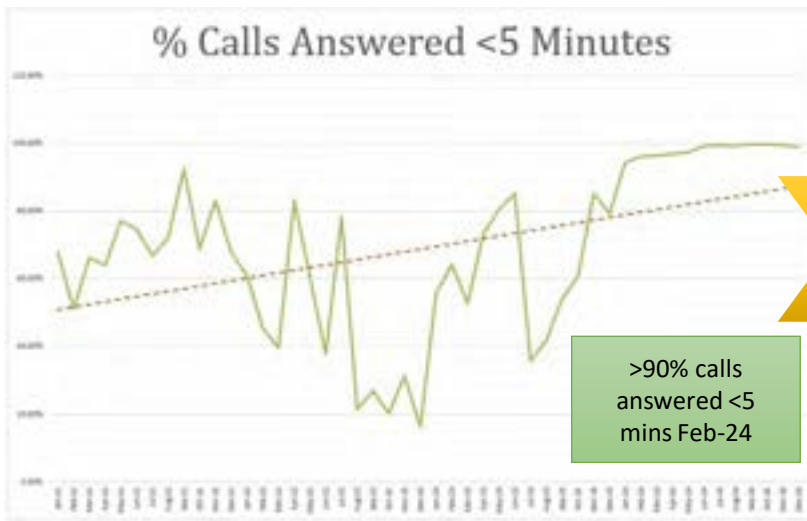
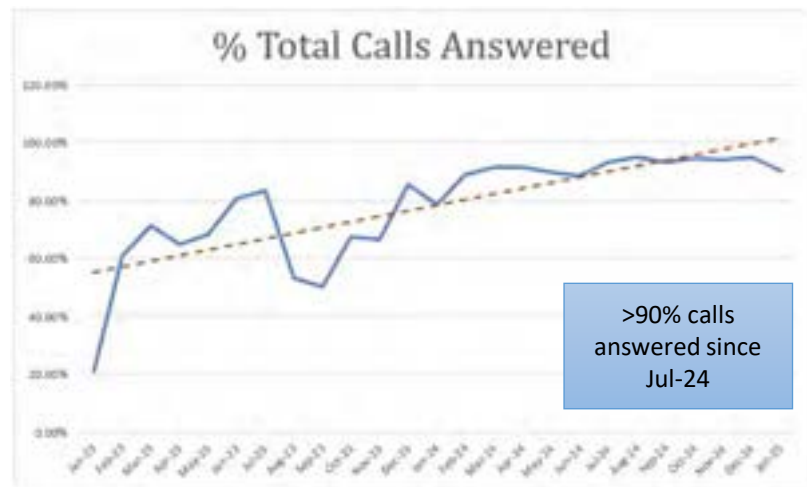


# Countermeasure Summary: PATIENT

**Project/Matric Name:** Improved Patient Experience with the Outpatient Contact Centre

**Owner:** Outpatient Contact Centre  
Centralised Outpatient Services  
**Metrics:** 90% of all incoming calls answered  
90% calls answered within 5 minutes

## 1. Historic Trend Data



## 2. Stratified Data

*% of calls answered within 5 minutes*

**Jan 2023**  
**16.12%**

**Jan 2024**  
**79.29%**

**Jan 2025**  
**98.99%**

99.56% calls answered <5 minutes Sep-24, highest since Sep-20

Longest time to answer 40 mins Sep-23, reduced to 7 mins Oct-24

13,649 calls answered Oct-24, highest in 6 years

Zero calls lasted more than 20 minutes Oct-24

Actual talk time <5 minutes 79.45% Oct-23 to 90.62% Jan-25

Amended open and close times until optimum times achieved ie, 08:00 to 17:00

Reviewed data trends for high call periods, and planned rosters accordingly eg, lunch breaks and after a bank holiday etc.

Managed ERS/long-waiting patient expectations of wait times to avoid frequent same patient contacts

## Improvement Initiatives

Improved telephone scripts for call efficiency, including closing a call

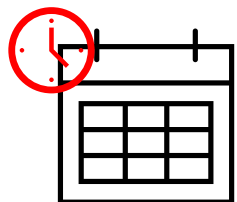
Worked with other services to review their letters etc to reduce inappropriate calls intended for another team

Introduced Outpatient Request Portal to reduce patients on hold, and new reporting and stats eg, talk time

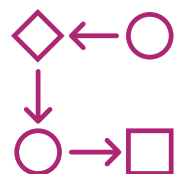
Worked closely with each Call Handler to improve call quality and share learning

Improved internal and external training eg, Suicidal Conversations and robust escalation process

# ASCR Patient First Services: PROPOSAL



*Strategic connectivity*  
**Meetings & Governance Infrastructure**



*Productivity*  
**Breast Care Service**  
**One Stop Clinic**



*Patient Experience*  
**TBC**

An area in which there is already appetite for and evidence of improvement work

1. Aligning improvement work with divisional priorities and infrastructure
2. A **“short burst” injection of resource** to propel and foster a culture of continuous improvement
3. Empower staff with a clear understanding of how their daily work contributes to the divisional and trust wide agenda and develop their use of the tools to turn the dial on key metrics

An area with ownership of a key strategic priority and recognises the need for support

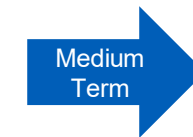
1. Aligning improvement work with divisional priorities and infrastructure
2. **Allocated resource to analyse** the problem in detail
3. Independent listening and feeding back
4. Disciplined timeline and approach to improvement process
5. Embed an Improvement Huddle to deliver and sustain ongoing improvement work

An area with ownership of a key strategic priority and the scale and/or complexity of the challenge require specialist improvement skills as an intervention

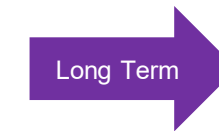
1. Aligning improvement work with divisional priorities and infrastructure
2. **Allocated resource to lead and deliver** the end-to-end improvement process
3. Independent listening and feeding back
4. Disciplined timeline and approach to improvement process
5. Embed an Improvement Huddle to sustain and develop further improvement work



**QUICK WINS**  
 Just do it!  
**LOW COMPLEXITY:**  
 6-12 per year

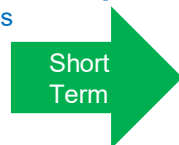


**A3 PROBLEM-SOLVING**  
 Data and evidence driven problem solving on key contributors for step change improvement  
**MEDIUM COMPLEXITY**  
 3-6 per year



**“WICKED PROBLEMS”**  
 Intractable issues/ end to end process improvement  
**HIGH COMPLEXITY**  
 1-2 per year

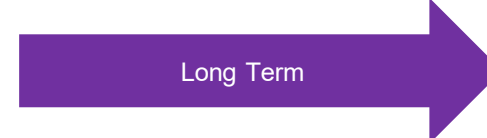
Discovery Phase: **End March 2025**  
 Review & analyse Current Meetings Structure/Time/Audiences



Discovery Phase: **End March 2025**  
 Observe and analyse clinic end to end processes



Discovery Phase: **TBC**



## Current 2025 Proposal

**NBTCARES**

# Next Steps

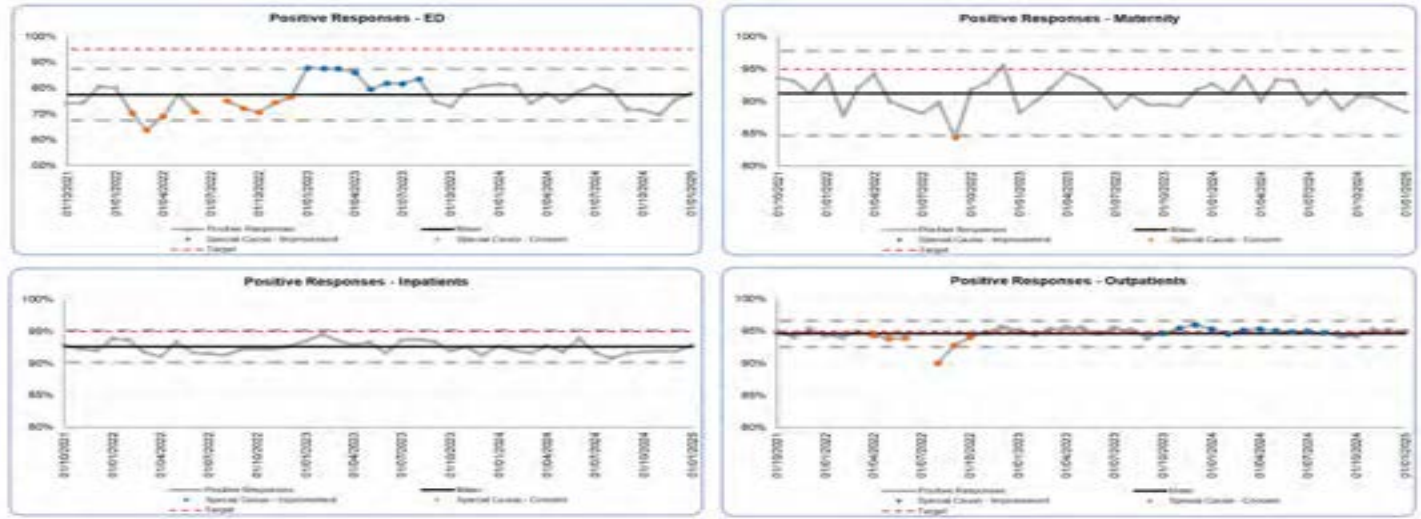
- Divisional Business Partnering Model Rollout – **ALL DIVISIONS**
- National Trust Board Education Programme:  
Continuous Improvement: **Coming Spring 2026**
- Patient First improvement priorities refresh for NBT & UHBW to inform further alignment on draft Group/Trust level priorities – **In Progress**

# APPENDIX: IMPROVEMENT PRIORITY MARCH 2025 REPORTS



<b>Our 3-5 year target:</b>	<b>Executive Lead</b>
Upper decile performance against non-specialist acute hospitals with a response rate of at least 10% <i>(based on June 2022 baseline)</i>	Steve Hams, CNO

**Latest Performance (Jan 25 data – Feb 25. Board IPR)**



**Overall** – FFT metrics remain stable, within normal statistical range.

**OP** – has sustained special cause variation (improvement) during 2024 to date.

**Maternity** – early signs of downward trend but not yet statically significant.

**All others** – within a normal statistical range pattern.

**FFT provides a beneficial 'Watch metric' but is not helpful as a breakthrough driver metric. We are now developing proposals to align monthly surveys to national survey actions during 2025, phased in line with national survey programme.**

<b>Key progress in last Quarter</b>	<b>Key aims next Quarter</b>	<b>Key challenges, risks, for awareness</b>
<p><b>1. 'Near Real Time insights and actions</b></p> <p>a) <b>PEP healthcare system</b> (social listening &amp; FFT thematic review platform) 18 mths historic data (140k comments) input into the system and weekly ongoing data feeds set up. Small project team formed and first 3 pilot areas now live with system.</p> <p>b) <b>Patient Conversations</b> (narrative patient feedback obtained by volunteers or staff) – Year 1 evaluation report reviewed and approved by PCEC. First Pt conversations held with patients with learning disability. Reviewing approach to run within Radar system to facilitate expanded programme</p> <p><b>2. Shared Decision-Making (SDM)</b></p> <p>a) <b>Metrics</b> - Embedding existing SDM approach into 'business as usual' with sustained outcomes &gt; National CQUIN.</p> <p>b) <b>Training</b> – CPD funded programme for nurses and midwives has been co-created with Cardiff University. Now available..</p> <p><b>3. Enhancing Clinical Communication:</b> Sensitively &amp; effectively communicating important clinical information, such as a concerning clinical diagnosis. Draft charter reviewed with patient group. Now liaising with PF Team to support approach to wider healthcare professionals' feedback. Reviewed with CNO as exec sponsor.</p>	<p><b>1. Strategic approach to Patient Experience</b></p> <p>a. <b>UHBW alignment</b> – Group and SMS Programme context. Comparing approach to Patient First breakthrough objective and there is good opportunity to align. Recommending this shift through Patient First Steering Group and as part of 25/26 Quality Account priorities.</p> <p>b. <b>Feedback metrics and approach</b> – seek to align our approach with UHBW, where appropriate. Simple example being complaints response timescales. But will also apply to how we consider FFT and other surveys.</p> <p><b>2. PEP Healthcare system</b> – continue project delivery in line with Charter. Test feasibility for PEP running FFT survey programme as well as the thematic review of outputs from current system supplier and social listening. Currently in discussion with supplier.</p> <p><b>3. Patient Conversations</b></p> <ul style="list-style-type: none"> <li>Continue programme having confirmed benefits and with PCEC endorsement.</li> <li>Investigate expansion options (within existing resources) – e.g. through Radar.</li> <li>Carry out more LD conv. and with pts not speaking English as first language.</li> </ul> <p><b>4. Shared Decision-Making</b></p> <ul style="list-style-type: none"> <li>Continue UHBW engagement (per their Exp. of Care Strategy)</li> <li>Finalise plans for SDM training rollout (supported by approved CPD funding)</li> </ul> <p><b>5. Enhancing Clinical Communication</b></p> <p>Review and further develop draft Charter through wider clinical engagement and to frame next steps into short, medium and long term requirements and associated resources.</p>	<p><b>Main challenges/risks</b> across all 3 key projects relate to ability to progress improvement projects in line with intended plan when faced with competing pressures and financial constraints meaning this may not take priority within clinical teams.</p> <p><b>Mitigated through</b> clear engagement and comms. to involve the right people at the right time and hone approach to be as time-efficient and simple as possible.</p> <p><b>Digital risks</b> for longer term around systems used for SDM (Cemplicity) and FFT (Envoy) – need to determine longer term strategy for each. Mitigated through active dialogue with IMT colleagues and UHBW colleagues within SMS Programme &amp; wider Group context.</p>
		<b>The ask of SLG</b>
		<p>1. <i>Continued support, ideas and participation in the corporate projects outlined in this report. In particular the establishment of monthly surveys aligned to the key actions from each national survey type.</i></p>

Mar. 2025	Project timeline on track	Metric is static, not moving towards target or positively towards trajectory
-----------	---------------------------	--



**Breakthrough Objective: 75% of patients are treated within 62 days on a cancer pathway.**

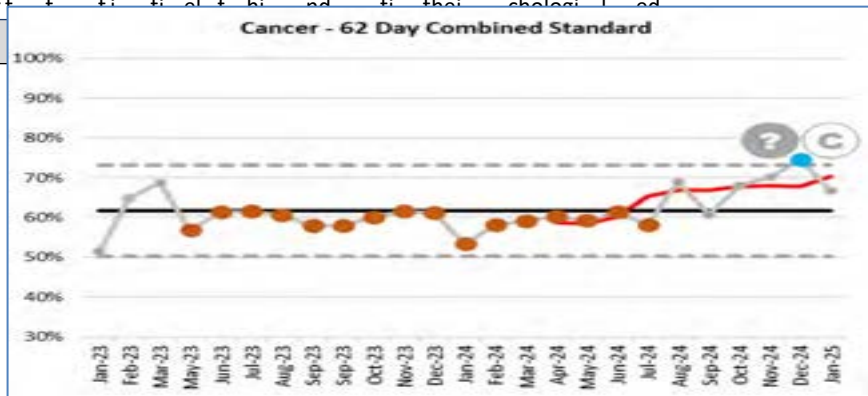
**2024/25**

**Our 3-5 year target:**

**Executive Lead**

NBT consistently meets the cancer access standards whilst providing cancer services that patients would recognise as supporting their treatment choices, whilst providing cancer services that patients would recognise as supporting their treatment choices.

**Steve Curry**



Month	Cancer Site	Total Seen	InTarget	Breach	Performance
January	Brain	15	14.5	0.5	96.67%
	Breast	85.5	54	31.5	63.16%
	Colorectal	28.5	15	13.5	52.63%
	Gynaecology	9	5.5	3.5	61.11%
	Haematology	14.5	10	4.5	68.97%
	Lung	14.5	8.5	6	58.62%
	Sarcoma	2.5	2.5		100.00%
	Skin	54.5	51	3.5	93.58%
	Upper GI	16	13.5	2.5	84.38%
	Urology	115	61	54	53.04%
<b>Total</b>		<b>356.5</b>	<b>237</b>	<b>119.5</b>	<b>66.48%</b>

- Overall, 62-day performance reported improvements since September 2024, reporting 73.38% in December.
- Urology, Breast and Colorectal are key areas of focus.
- As forecast, there was deterioration in January 2025 as backlog clearance was delivered across several tumour sites. This was driven by patient choice and capacity challenges over Christmas and New Year.

- Increased RALP capacity for January and February.
- Breast capacity increased through Locum and additional workforce.
- Improvement and maintenance of 28-day FDS standard which has improved the first part of cancer pathways.

- Maintain Robotic Assisted Laparoscopic Prostatectomy capacity to reduce backlog.
- Secure SWAG funding for continuation of recovery and improvement actions into 2025/26.

- Robot capacity and workforce capacity for continued backlog clearance.
- Patient choice in approach to Christmas.
- Delays in diagnostic pathways and BHOC.

<b>March 2025</b>	<b>Project timeline</b>	<b>Metric is on target or moving positively towards trajectory</b>
	<b>on track</b>	

Sustain/maintain >70 weekly hrs lost

Nick Smith, Chief Operating Officer



- Significant ongoing challenges with ambulance handover and flow out of ED, which plays through as deteriorated 12 hour delay position
- Refocus on delay related harm, noting excess deaths of 6 patients per day across BNSSG EDs resulting from delays

**t**

workbook

- Various TTA process improvement trials underway
- Ring before sending pilot with Monks Park Surgery
- NEL LOS improvement work launched across Divisions
- System wide UEC strategy workshop held
- Development of delay related harm action plan
- PSPs for high impact admission patients
- Highest number of referrals received into NHS@Home during Dec and Jan

- Design or Trustwide comms on delay related harm
- Design work for Every Minute Matters
- Review learning from March Kindness Month and incorporate into operational and transformational work for 2025/26
- Agree action plan to reduce primary care referred NEL medical admissions
- Develop system response plan from SWAST alternatives to conveyance audits held 10 & 11 March - ? Care co-ordination opportunity
- Leaving Hospital Strategy Steering Group starts work

ED as a POS

- Impending launch of Timely Handover Plan
- High proportion of P1 cancellations –response work has started

harm? What is our specific role in this? How can we support our teams?

Feb 2025

Project timeline on track

Metric is off target or moving negatively away from trajectory

**INNOVATE TO IMPROVE Breakthrough Objective:**

Our 3-5 year target:

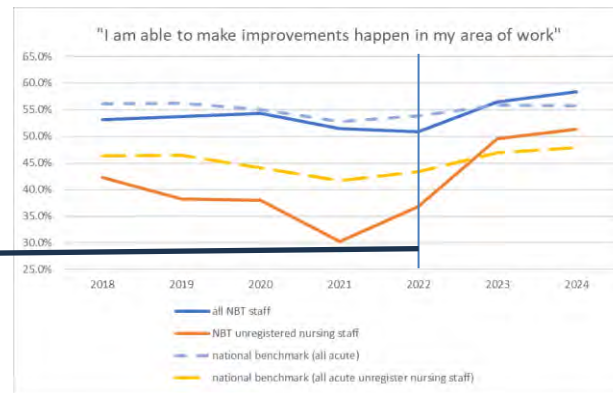
Executive Lead

Increase number of staff able to make improvements in their areas to 60%

Tim Whittlestone, CMO

Latest Performance

Baseline set on 2022 data



**2024 staff survey results: 58.4%**

- Up 2 percentage points on 2023
- 2.6 percentage points above benchmark

**Unregistered nurses result: 51.4%**

- Up 1.8 percentage points on 2023
- 3.5 percentage points above benchmark

Key progress in last Period	Key aims next Period	Key challenges, risks, for awareness
<ol style="list-style-type: none"> <li>1. First draft of Innovation Strategy</li> <li>2. Completed Clera pilot in Q4</li> <li>3. Living well with COPD – evaluation completed</li> <li>4. Innovation in Group Operating model development with standard project tracker</li> <li>5. 50*365 Copilot AI licences purchased</li> <li>6. AI meeting with Jean Golding Institute</li> </ol>	<ol style="list-style-type: none"> <li>1. Group Innovation Strategy finalised by Q2</li> <li>2. Next i2i showcase scheduled for Q1 with LEAP</li> <li>3. Clera pilot evaluation report in Q1</li> <li>4. MS365 Co-pilot trial in Q1</li> <li>5. Next steps on LWWCOPD</li> <li>6. Bladder cancer diagnostic trial in Q1</li> <li>7. International Trade mission</li> <li>8. Backtrack trial focussed on staff with UHBW in Q1</li> <li>9. Ear Switch trail scoping in Q1</li> </ol>	<ol style="list-style-type: none"> <li>1. Innovation enablers – digital, finance, agreed strategy</li> <li>2. Permission to innovate – culture</li> <li>3. Fear vs Opportunity</li> </ol>
		<b>The ask of SLG</b>
		<ol style="list-style-type: none"> <li>1 Support for Group innovation infrastructure</li> <li>2 Divisions to review staff survey results for Question 3f and share insights and plans</li> </ol>

March 2025

Project timeline on track

Metric is on target / moving towards trajectory

**Breakthrough Objective 2024/25: Deliver the planned levels of recurrent savings in 2024/25** **SUSTAINABILITY – Making best use of limited resources**

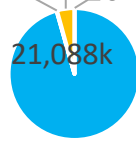
**Our 12-month target:** **Executive Lead**

To deliver at least 1% higher CIP than the national efficiency target Elizabeth Poskitt

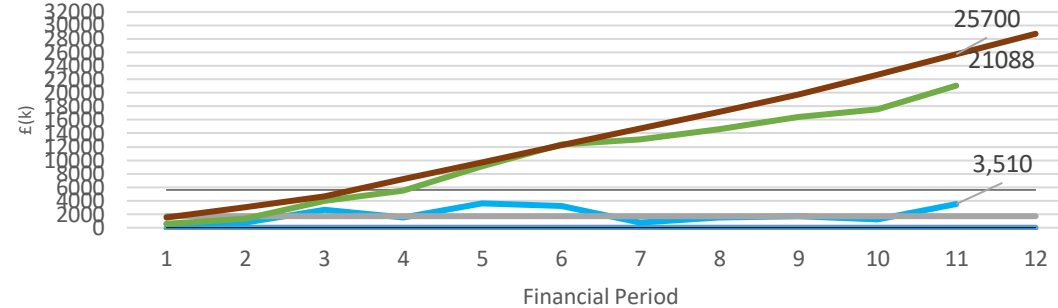
**Latest Performance**

CIP Delivery (K) M11- Total including

25k Pipeline = £22,062  
 948k Implement Planning  
 21,088k Pipeline



Monthly CIP Completion SPC



■ Current Completed £k FYE

— Actual Completed CIP Movement £k

— Mean  
 — UCL

Key progress in last Month	Key aims next Month	Key challenges, risks, for awareness
----------------------------	---------------------	--------------------------------------

- Delivered £3.6m of CIP in month, £4.5m off track overall.
- £2m achieved from ERF Overperformance.
- £440k delivered from Facilities schemes.
- All Divisions / Directorates updated Tracker with final profiling and removal of Pipeline / uncertain schemes.
- Workstream leads for 2025 / 2026 schemes notified and updates requested on progress from April
- First meeting of NBT Co

- Final transacting of remaining 2024 / 2025 schemes.
- Set up of Hospital Group Joint Non-Pay Group.
- Working with UHBW colleagues on expanding Commercial Group to cover Hospital Group wide opportunities.
- Headcount growth data to be shared
- Productivity governance and data

- Development of 2025 / 2026 schemes as 9 out of 14 areas have significant unidentified plans.

**The ask of SLG**

- Continuable development of Pipeline for 2025 / 2026 as most divisions / directorates still have significant unidentified.
- All areas to be begin working on 2025 / 2026 schemes and to move plans to Planning / Implementation.

**M11  
2024 / 2025**

**Project timeline**

**Metric is on target or moving positively towards trajectory**

Our 3-5 year target:

**Executive Lead**

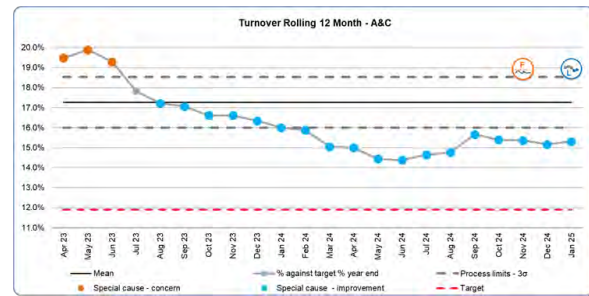
**Staff Turnover**  
**Patient First – Breakthrough objective**  
 23/24 – original target 16.5% (12.3% achieved)  
 24/25 - original target 16% (refreshed to 11.9%)  
 27/28 – original target 13% (refreshed to 10%)

Peter Mitchell, Interim Chief People Officer

**Latest Performance**

**Overall, turnover** has followed a statistically significant improvement trend since November 2022. Turnover at the end of Jan-25 was 11.69% below our March 2025 target of 11.9%. Our turnover targets for 2025/26 were set in our long-term retention plan at 11.3% which is being reviewed in the context of divisional operational plans for 2025/26.

**Administrative and Clerical Turnover**



As part of the next stage of the retention work within our People Patient First strategic priority a focus and deep dive into Administrative and Clerical (A&C) staff turnover will be carried out.

A&C has the highest turnover of any staff group in the Trust as at Jan-25

In Corporate Directorates, Chief Executive, Operations and Finance have the highest turnover. A deeper dive to determine the drivers will be required, e.g., if temporary project resource planned to be fixed term is contributing to high turnover.



Division / Directorate	Jan 2024	Jan 2025
339 Women and Childrens Division	16.7%	17.8%
339 Medicine Division	20.1%	16.9%
339 Corporates	18.3%	16.4%
339 Neurosciences & Musculoskeletal Division	17.6%	15.8%
339 Facilities Division	10.9%	13.0%
339 Anaesthesia, Surgery, Critical & Renal Division	11.3%	12.7%
339 Core Clinical Services Division	13.7%	12.4%
<b>Grand Total</b>	<b>16.3%</b>	<b>15.2%</b>

All actions from our 1-year retention plan are now complete and we are progressing our LT retention plan work. Highlights from last quarter:

Driver	Action	Impact
Flexible working	Further guidance and case studies have been developed to support staff thinking of leaving us for caring or travelling reasons.	By 2026 support 110 staff who would otherwise have left us to take a career break. Exit data being monitored to review early signs of uptake.
Flexible working	Tools to support managers to lead flexible teams	Workshop feedback -100% positive and 70% of attendees report using the learning to enable new flexible working in their teams.
Workforce data	Further data was provided to the People Business Partners	Data on leaving reason and 2024 NSS analysis will be used to improve staff experience and reduce turnover.
New Starter Experience	Initial evaluation of the pilot My First 90 Day Induction tool taken place and a further roll out and changes to length taken place	Initial evaluation showed a slightly better new starter experience but due to small pilot size an increase in pilot size needed.

Key work programmes from our LT Retention Plan that will be delivered in the next quarter that will continue to improve staff experience and improve retention include:

Driver	Action and Impact	Status	Due
Culture	Living Our Values work to progress. 1. New Gateway platform to support staff with different situations has been developed and is being shared with stakeholders for their feedback. 2. Toolkit and Divisional engagement taking place March/ April.	In Progress	April 25
Long Term Plans	Workshop being held for People Business Partners to review long term plans and agree focuses for 25/26.	In Progress	April 25
Career development	Develop a framework for career coaching to support staff develop their careers at NBT	About to begin	April 25
New Starter Experience	Version 2 – using pilot teams feedback will be rolled out as part of Trust corporate induction tools	In Progress	May 25

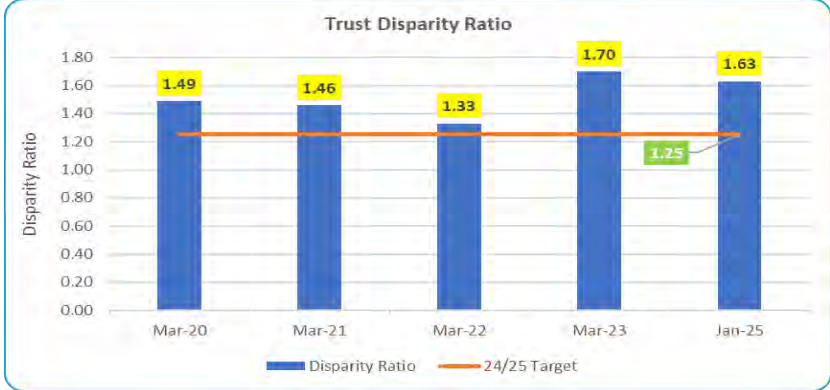
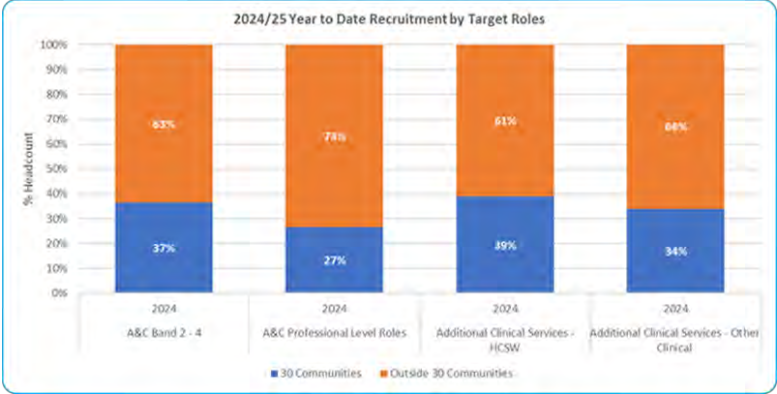
Current financial challenges have resulted in increased recruitment controls being implemented and actions are being taken to address over-establishment of workforce in some areas.

**The ask of SLG**

Continued focus on staff retention and engagement with the actions being implemented.

**March 2025** **Project timeline on track** **Metric is on target or moving positively towards trajectory**



Breakthrough Objective/: Commitment to our Community		2024/25
		<b>Executive Lead</b>
<p><b>Disparity Ratio</b> - Breakthrough objective: Reduced disparity ratio for ethnic minority candidates from 1.70 (end of 2022/23) to <b>1.25</b> by end of March 2025. Target has been reviewed and refreshed to 1.55 for 2025/26, acknowledging the current position and time taken to effect improvement.</p> <p><b>% of Recruitment into Targeted Roles</b> – target currently being set in partnership with divisions &amp; professions through a review of data and current and planned interventions. The Trust target for 2025/26 has been agreed as 38%</p>		Peter Mitchell, Interim Chief People Officer
Latest Performance		
<p><b>Disparity Ratio</b> – (likelihood of applicants from ethnic minority backgrounds being appointed over white applicants from shortlisting – Workforce Race Equality Standard metric).</p> <p>The January disparity ratio was 1.63 (1.66 in December), the Trust has now refreshed its target for 2025/26 to 1.55 in line with a deeper understanding of the drivers of disparity and the interventions and time require to effect change.</p>		<p><b>% of Recruitment into Target Roles from our 30 Most Challenged Communities</b> – the bar chart shows the year-to-date proportion for recruitment from our 30 most challenged communities into our target roles – overall we are at 35%. Improvement target for 2025/26 has been set at 38%.</p>
		
Key progress in last Period	Key aims next Quarter	Key challenges, risks, for awareness
<p><b>Positive Action Programme</b> – all vacancies now include a statement particularly encouraging applications from underrepresented groups, and more targeted approaches are being used as required. This includes the Diverse Recruitment Panel Members pilot scheme, which has been evaluated and is now moving to Divisionally-owned 'business as usual' with more panel members being recruited.</p> <p><b>C2C Listening Event</b> – External event took place in November. A lot of valuable feedback has been collated which is being used to inform the next iteration of the plan.</p>	<ul style="list-style-type: none"> <li>•Close of funded element of community work.</li> <li>•Support candidates with active applications through the interview/onboarding process.</li> <li>•Capitalise on increased vacancies to support our community candidates in to work</li> <li>•Interview Feedback review underway with staff networks canvassed for feedback. New pilot for standardised feedback to be created by end of Q3</li> <li>•Fairer Recruitment A3 started to understand the core problems in disparity ratio. Toolkit for managers to be developed following project conclusion</li> </ul>	<ul style="list-style-type: none"> <li>•Funding for a large amount of the community outreach work will come to an end 30/03/25 meaning 2 roles will cease to exist (Community Engagement Officer and Employability Skills Coach)</li> <li>•Risk of reductions in non-clinical external recruitment/workforce controls resulting in inability to offer roles to community candidates.</li> </ul>
		<b>The ask of SLG</b>
		<ul style="list-style-type: none"> <li>• Divisions/services to finalise targets as part of Operational Planning.</li> <li>• Agree where we have the discussion about this priority in light of reduced external recruitment. =</li> </ul>
<b>March 2025</b>	<b>Project timeline on track</b>	<b>Metric is off target or moving negatively away from trajectory</b>

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	2024 Staff Survey Results Summary Report		
<b>Report Author:</b>	Caroline Hartley, Associate Director of Culture and Staff Experience		
<b>Report Sponsor:</b>	Peter Mitchell, Interim Chief People Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
			X
	<p>The purpose of this report is to brief the Trust Board on the key results of the 2024 National Staff Survey (NSS), highlight areas where NBT has performed well and not so well, and suggest some areas of focus for 2025-26.</p> <p>We have now received the national benchmarking results from the National Co-ordination Centre and this gives us much more detailed data on our results and our position in comparison with other Acute Trusts. This report aims to present a more detailed summary of our results.</p>		
<b>Key Points to Note</b> <i>(Including any previous decisions taken)</i>			
<p>The 2024 National Staff Survey results present a largely positive picture, with our best response rate ever (62%) and improving People Promise scores.</p> <p>While our improvements in 2024 are not as great as in 2023 which saw very significant improvements, they do demonstrate that we are continuing to make progress in all People Promise areas. We have now received the national benchmarking data, (our previous report made comparisons with around 50% of organisations that used IQVIA as their survey provider), and we can see that our NBT People Promise scores have slightly improved due to the larger weighting of National comparator compared to IQVIA comparator scores initially received.</p> <p>It is very pleasing to note our results on some core questions in the Survey, which are often reported in the press and externally:</p> <ul style="list-style-type: none"> <li>• NBT is the top of the large Acute and Community Provider Trusts in the South-West for staff recommending the Trust as a place to work (second year in a row).</li> <li>• NBT is also number one in the South-West for staff recommending the standard of care to friends or relatives.</li> <li>• NBT is second in the South-West for staff believing that care of patients is our top priority</li> <li>• NBT &amp; UHWBW combined are leading in the South-West for these areas.</li> </ul> <p><b>86%</b> of NBT staff survey results are same or better than the National comparator average. This equates to the same ratio as 2023. In 2023 our largest improvement was staff recommending NBT as a place to work, which increased to 70.3%. This has dropped slightly to 69.5%. However, this is still positive and is 8.6 % better than the national average.</p> <p>NBT is ranked third in the South-West Acute and Community Providers grouping across all the People Promise scores, just below UHWBW (less than 1% difference in scores).</p>			

<b>Strategic and Group Model Alignment</b>	
<p>The National Staff Survey (NSS) results link to our Patient First strategic People Priority '<i>Proud to Belong</i>' and to the actions and plans aligned to this, including our Clinical Strategy, our EDI plan and our Long-term Retention and Workforce Plans.</p> <p>The way in which these results are shared, reported and, most importantly, responded to, will support our ambition to be a successful Hospital Group. We are also committed to working together on shared 'hot spot' areas. We will review the areas where one Trust may have performed better than the other and maximise the opportunities for shared learning.</p>	
<b>Risks and Opportunities</b>	
<p>There is a risk with the NSS if we do not communicate the results to staff or respond to them in a timely way. This is particularly important given the high level of engagement and commitment shown by staff who have taken time to complete the 2024 survey. They may feel less inclined to engage with future surveys if they do not get a clear sense of the results and the actions we propose to take in response to them.</p> <p>The opportunities come from having had such a high response rate and therefore having a clear and current understanding of how our staff are feeling about working at NBT. We can use the NSS data to really tailor and target our responses and interventions to the greatest effect.</p>	
<b>Recommendation</b>	
<p>This report is for <b>Information</b></p> <p>The Board is asked to note this paper and its recommendations.</p>	
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>	
Executive Management Team	5 <sup>th</sup> March 2025
People and EDI Committee	11 <sup>th</sup> March 2025
Senior Leadership Group	18 <sup>th</sup> March 2025
<b>Appendices:</b>	Appendix 1: Presentation summary of 2024 NSS results (full benchmark results and breakdown available in the board reading room)

## 1. Purpose

- 1.1 The purpose of this paper is to give a more detailed overview of the 2024 National Staff Survey results based upon the NSS benchmark results which have just been received.
- 1.2 Further, it is to present NBT's areas of strong and weak performance and suggest areas of focus for the coming year.

## 2. Background

- 2.1 The National NHS Staff Attitude Survey is an annual survey all NHS organisations are mandated to participate in. It is a strategic listening tool and ultimately supports the Trust in improving staff experience, engagement, and is an enabler in delivering our Patient First Strategy at NBT.
- 2.2 Our Staff Survey provider (IQVIA) released the survey results for substantive staff on their data portal on 16<sup>th</sup> December 2024.

- 2.3 The National Staff Survey Co-ordination Centre (NSSCC) released detailed benchmarked results on 26<sup>th</sup> February 2025.
- 2.4 The national embargo which allows full visibility of other organisations' results was lifted on 13<sup>th</sup> March 2025, meaning we can now understand our performance in the context of other comparable NHS organisations.
- 2.5 Divisions have been sent the detailed results for their areas, to allow for local planning.

### 3. Summary of Results

#### 3.1 Overview.

As detailed above, the 2024 results present a positive picture overall, continuing a positive trend in feedback from staff. Our big response rate means we can feel assured that these results are statistically valid and be reassured that it is reasonable therefore to take actions based upon these results.

- All People Promise themes, morale and engagement are above National comparator average. They have shown no statistically significant changes since 2023, except for '**We are always learning**' which is classed as a significantly higher and positive change.
- All People Promise scores/themes have shown a slight improvement on scores compared with NBT's 2023 scores, except for '**Staff engagement**' which has declined very slightly by 0.02 (not statistically significant).
- '**We are compassionate and inclusive**' is our highest scoring People Promise (PP) theme at 7.44. This is close to national comparator best of 7.69 and above the average of 7.21.
- '**We are always learning**' is our lowest scoring PP theme at 5.94. However it is close to national comparator best of 6.09 and above the average of 5.64
- A Divisional summary and comparison with 2023 results is shown here:

Division	Response Rate	Total People Promise Score (out of 90) 2023	Total People Promise Score (out of 90) 2024	2024 Ranking
Corporates	76.42%	60.82	62.12	1 <sup>st</sup>
NMSK	56.97%	60.81	59.86	2 <sup>nd</sup>
ASCR	56.26%	58.07	59.09	3 <sup>rd</sup>
Medicine	60.12%	58.46	58.38	4 <sup>th</sup>
CCS	63.40%	57.35	58.03	5 <sup>th</sup>
Facilities	70.62%	58.00	57.97	6 <sup>th</sup>
W&C	57.01%	54.91	56.33	7 <sup>th</sup>
NBT	62%	58.46	58.92	

- An Occupational Group summary and comparison with 2023 is shown here:

Staff Group	Response rate	Total People Promise Score (out of 90) 2023	Total People Promise Score (out of 90) 2024	2024 Ranking
Add Prof Scientific and Tech.	65.80%	58.46	59.81	2nd
AHP	63.05%	56.27	59.75	3rd
Nursing & Midwifery Reg.	62.58%	57.97	58.9	4th
Medical & Dental	42.86%	58.21	58.74	5th
Estates & Ancillary	59.32%	58.07	58.63	6th
Additional Clinical Services	58.46%	58.20	57.58	7th
Healthcare Scientists	63.43%	56.75	55.94	8th
NBT	60%	58.46	58.92	

- Our People Promise Scores were not as positive as UHBW's, except in 2 areas: '*We are always learning*' and the theme of '*morale*', although overall the scores are very close with less than 1% difference in the total PP scores (59.4% UHBW v 58.9% NBT). This is helpful for our Group working as we can learn from each other in certain areas but culturally are in a similar position overall.

### 3.2 Highlights

- The most positive areas overall are around staff recommending NBT as a place to work and receive treatment, our care of patients and our actions on health and wellbeing.
- There is also a clear picture of staff feeling that relationships at work are good and that people are kind and understanding of one another. **(See slide 12, Appendix 1 for details of our highest scoring questions)**
- The theme of 'our organisation' **(slide 13)** shows that staff's perception of NBT as a positive employing organisation is our strongest area.
- Our WRES data has shown some pleasing improvements this year **(slide 16)**, particularly around bullying and harassment, discrimination (from staff/colleagues) and career progression.
- Our WDES data is also mostly positive **(slides 17-18)** particularly around disabled staff feeling valued at NBT. Our position compared to national average is also positive, although there were some areas of slight decline this year which we need to work on.
- Staff Appraisals are also a key highlight this year – both the number and quality of appraisals undertaken **(see slide 19)**. It is also very interesting to note the different experience of global majority and white staff when it comes to appraisals, with global majority staff appearing to have a much more positive experience. The differences are striking:



Global majority staff have scored significantly better than white staff and NBT average for appraisal quality.	NBT	White	Global Majority
Appraisal People Promise sub-score	5.28	4.75	6.55
Q23b - It helped me to improve how I do my job (Yes, definitely).	25.30%	16%	49.3%
Q23c - It helped me agree clear objectives for my work (Yes, definitely).	37.03%	30.1%	54.4%
Q23d - It left me feeling that my work is valued by my organisation (Yes, definitely).	34.26%	28.3%	50.2%

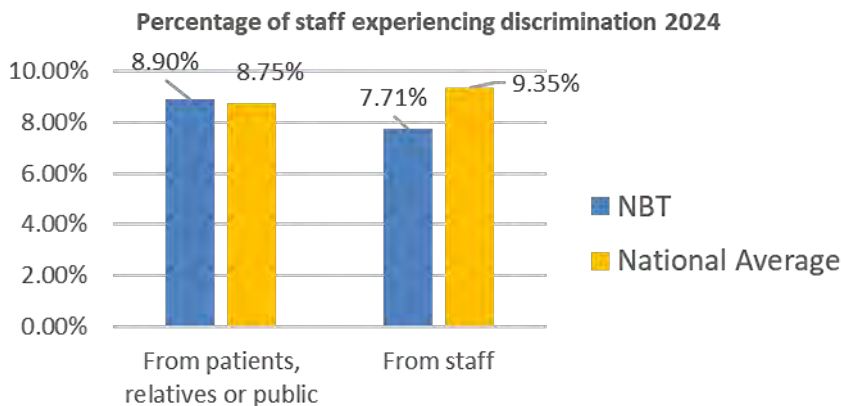
- Finally, our results on the theme of retention and 'thinking of leaving' (**slides 23 and 24**) show a generally improving picture both in comparison to NBT's 2023 results and the national average.

It is pleasing to note that these areas of improvement reflect where we have invested particular effort, time and focus in 2024 through our EDI, Long-term Retention and Commitment to our Community Plans and People Promise work, accepting that there is still more to do.

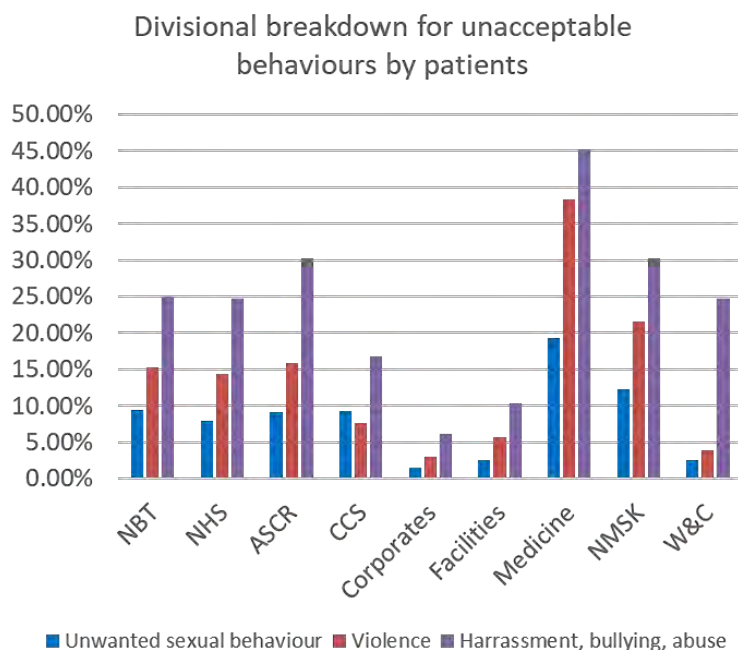
### 3.3 Lowlights

There are a few areas of real concern, where we have performed poorly and where we need to focus effort. These are all around the theme of health, wellbeing and safety at work.

- Slide 14** sets out our poorest scoring questions, and these are around the theme of violence and aggression at work (staff safety), discrimination from patients/service users and burnout.
- Sexual misconduct from patients and service users is a clear concern (although our scores for staff-on-staff sexual misconduct have improved this year).
- Where staff have experienced discrimination, it is significantly on the grounds of ethnicity (**see slide 21**). Certain staff groups are more likely to experience this (Registered nurses and midwives) and this is also more prevalent in Medicine Division.



- On the theme of staff safety at work, **all questions relating to unacceptable behaviours from patients were worse than national average.**
- In the last 12 months, NBT staff experiencing physical violence from service users, their families or members of the public increased by 1.17% since 2023 and this is 0.96% worse than the National comparator average.
- The staff group with the highest percentage of physical violence from patients was nursing and midwifery at 25% (up 0.5% since 2023) and Additional Clinical Services 25.9% (up 5.2% since 2023).
- Staff groups with the highest percentage of unwanted sexual behaviours from patients is Allied Health Professionals at 21.8% (up 5.8% since 2023), Additional Clinical Services 13.8% (up 0.7% since 2023) and Nursing & Midwifery, 12.9%
- Medicine Division scored most poorly on the questions around violent behaviour from patients, although NMSK, ASCR and Women and Children's Health scored poorly on bullying, harassment and abuse.



### 3.4 Suggested areas of focus

The area of health and safety (particularly violence and aggression from patients) is an area that must be prioritised. While the key drivers for this may be understood we need to take clear steps and actions to support our staff better.

Similarly, and linked to this, the impact of discrimination on staff needs greater focus – both in addressing this with the perpetrators, supporting staff who may have suffered and seeking to prevent it happening in the first place.

When it comes to the overall experience of our staff, Healthcare Scientists stand out as a group that we need to work closely with.

Divisionally, Women and Children's Health is showing poor scores in many areas, while Medicine staffs' experience of violence and aggression is a clear hot spot area.

Many of our existing plans cover the other areas requiring focus and attention, and actions are in progress so it is recommended that these continue, using the 2024 Staff Survey results as clear reference point.

#### **4. Summary and Recommendations**

- 4.1 This paper outlines the key themes and high/lowlights from the 2024 National Staff Survey. It is recommended that the Board **note** this report and its contents.

# National NHS Staff Survey 2024

National Staff Survey Co-ordination Centre Benchmarking  
(Including regional comparisons)



**Caroline Hartley**

Associate Director of Staff  
Experience & Culture

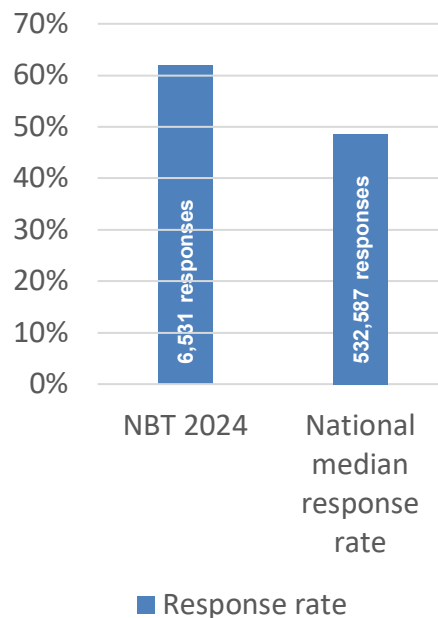
March 2025

# Headline results

N.B. All results in this presentation are substantive staff only

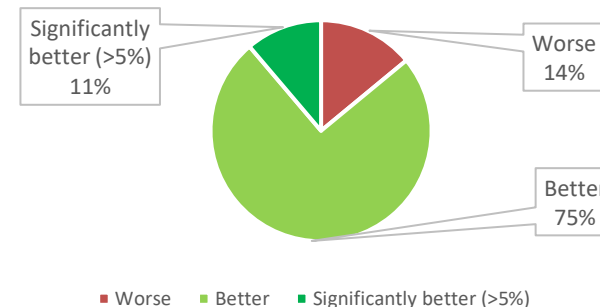
- Comparator average based on **122 Acute & Acute and Community Trust** organisations.
- **86%** of NBT staff survey results are same or better than the National comparator average. This equates to the same ratio as 2023.
- NBT is number one in the South-West for people recommending the Trust as a place to work.
- NBT is number one in the South-West for recommending standard of care to friend or relative.
- NBT is second in the South-West for care of patients being the top priority.

## Response rate comparison

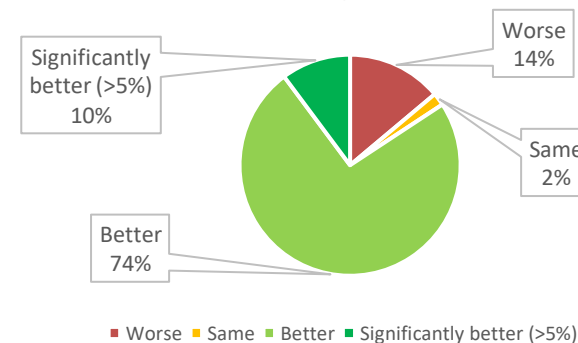


**13% higher than National average**

Percentage of questions rated against National average 2023



Percentage of questions rated against National average 2024

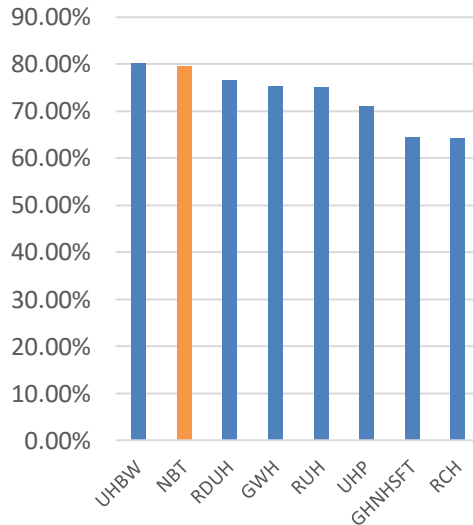




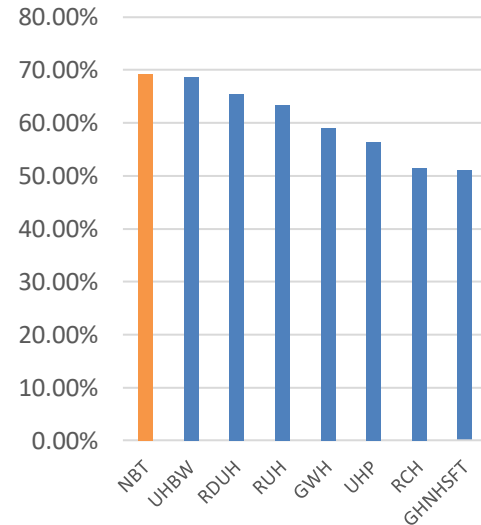
# Comparison highlights

- **National:** South-West region currently ranked 2nd for People Promise scores, after South-East.
- **Regional ICS:** BNSSG currently ranked 3rd for People Promise scores, after Somerset in 1<sup>st</sup> and Dorset in 2<sup>nd</sup> places.
- NBT is second in the South-West for care of patients being the top priority
- NBT is number one in the South-West for people recommending the Trust as a place to work.
- NBT is number one in the South-West for recommending standard of care to friend or relative.
- NBT & UHWBW combined are leading in the South-West for these areas.

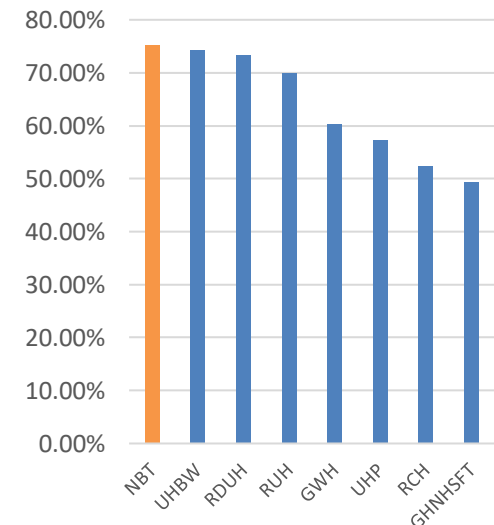
**Q25a Care of patients / service users is my organisation's top priority. (Agree/Strongly agree)**



**Q25c I would recommend my organisation as a place to work. (Agree/Strongly agree)**



**Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Agree/Strongly agree)**



# Regional People Promise Comparison



Key:

	Highest scoring	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
	Lowest scoring									
GHNHSFT	7.67	6.48	7	6.48	6.05	6.84	7.21	7.18	6.35	
UHBW	7.52	6.19	6.90	6.32	5.75	6.5	6.99	7.10	6.13	
NBT	7.42	6.10	6.85	6.24	5.92	6.34	6.86	7.06	6.13	
RDUH	7.46	6.16	6.76	6.26	5.26	6.38	6.89	6.96	6.11	
GWH	7.23	5.92	6.69	6.14	5.71	6.42	6.77	6.82	5.93	
RUH	7.35	5.96	6.71	5.95	5.57	6.19	6.83	6.92	5.89	
UHP	7.16	5.89	6.62	6.02	5.60	6.30	6.64	6.74	5.86	
RCH	7.08	5.84	6.52	5.96	5.27	6.07	6.67	6.56	5.79	

- **GHNHSFT** – jointly scored highest in all 9 themes. This is a dramatic turnaround as they scored lowest in 8 out of 9 themes last year in the regional comparison.
- **RCH** scored lowest in 6 out of 9 themes and ranked 8<sup>th</sup> in the region.
- **RDUH, RUH & UHP** each scored lowest in 1 out of 9 themes.
- **NBT** is not an outlier in any of the 9 people promise elements currently.
- **NBT** is 3<sup>rd</sup> in People Promise rankings, after **GHNHSFT** who were 1<sup>st</sup> and **UHBW** who were 2<sup>nd</sup>.
- **NBT** had the 3<sup>rd</sup> highest response rate after **GWH** who were 1<sup>st</sup> & **GHNHSFT** who were 2<sup>nd</sup>. \*NBT expenditure per % RR return is much lower than GWH and GHNHSFT

Staff Group	Response rate	Total People Promise Score (out of 90)	Ranking
GHNHSFT	65%	61.26	1 <sup>st</sup>
UHBW	54%	59.4	2 <sup>nd</sup>
NBT	62%	58.92	3 <sup>rd</sup>
RDUH	40%	58.24	4 <sup>th</sup>
GWH	71%	57.63	5 <sup>th</sup>
RUH	54%	57.37	6 <sup>th</sup>
UHP	42%	56.83	7 <sup>th</sup>
RCH	45%	55.76	8 <sup>th</sup>

# NBT / UHBW comparison

Key:




## NBT Top 5 questions above comparator average

Question	NBT ranking against National comparator	NBT	UHBW
25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (Agree/Strongly agree)	Significantly better (>5%)		
25c I would recommend my organisation as a place to work. (Agree/Strongly agree)			
Q23a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).			
Q11a My organisation takes positive action on health and well-being (Agree/Strongly agree).			
Q5c Relationships at work are strained (Never/Rarely).			

## NBT bottom 5 questions below comparator average

Question	NBT ranking against National comparator	NBT	UHBW
Q16c01 On what grounds have you experienced discrimination? Ethnic background (Yes).	Worse		
Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public (Yes)			
Q13a In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Yes).			
Q07b The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).			
Q16c02 On what grounds have you experienced discrimination? Gender (Yes).			

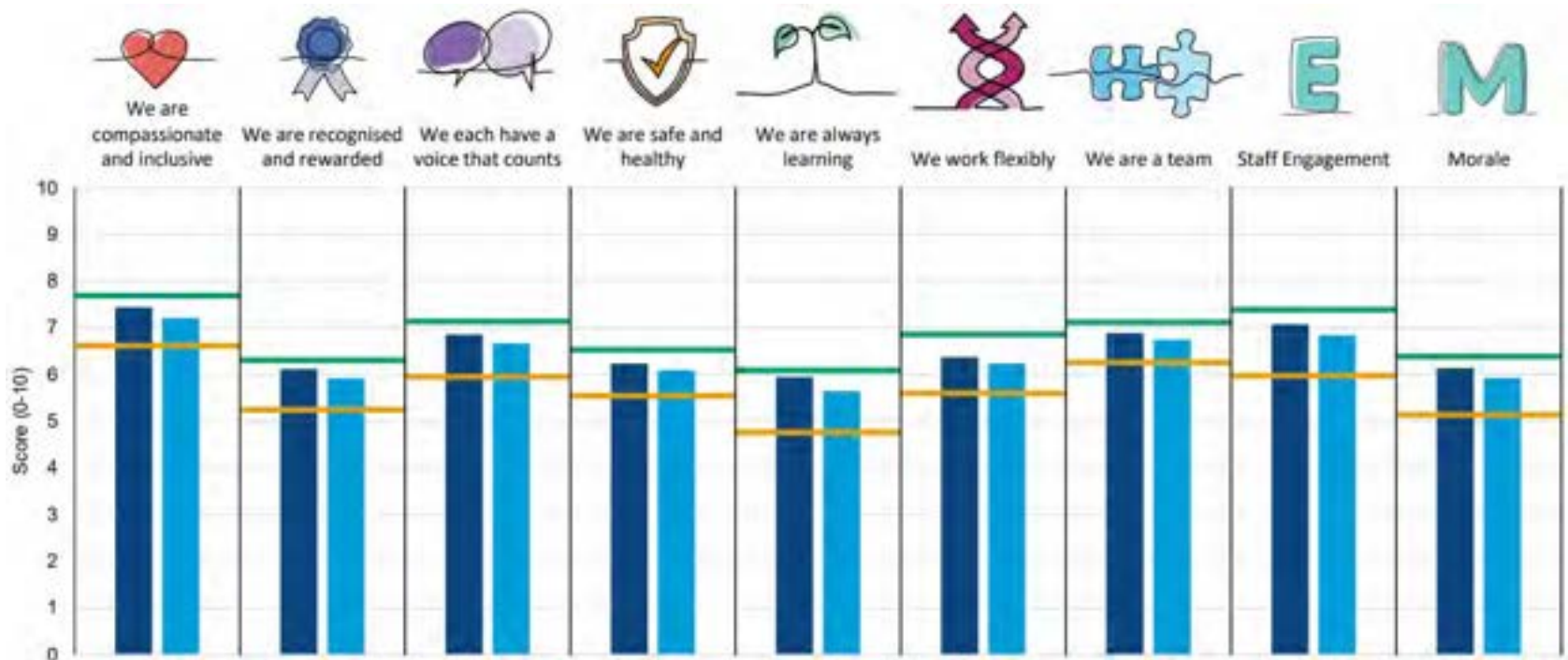
- UHBW were ranked higher by total People Promise scores compared to NBT.
- UHBW scored higher in 8 out of 9 themes.
- NBT scored higher than UHBW on 'We are always learning.'

Retention questions:

26b I will probably look for a job at a new organisation in the next 12 months. (Agree/Strongly agree)	Better	18.71%	19.67%	NBT better
Q26c As soon as I can find another job I will leave this organisation. (Agree/Strongly agree)	Better	18.8%	13.6%	UHBW better

# NBT People Promise Scores

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



Your org	7.44	6.12	6.86	6.23	5.94	6.37	6.89	7.08	6.14
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	6489	6498	6368	6435	6257	6445	6478	6495	6500

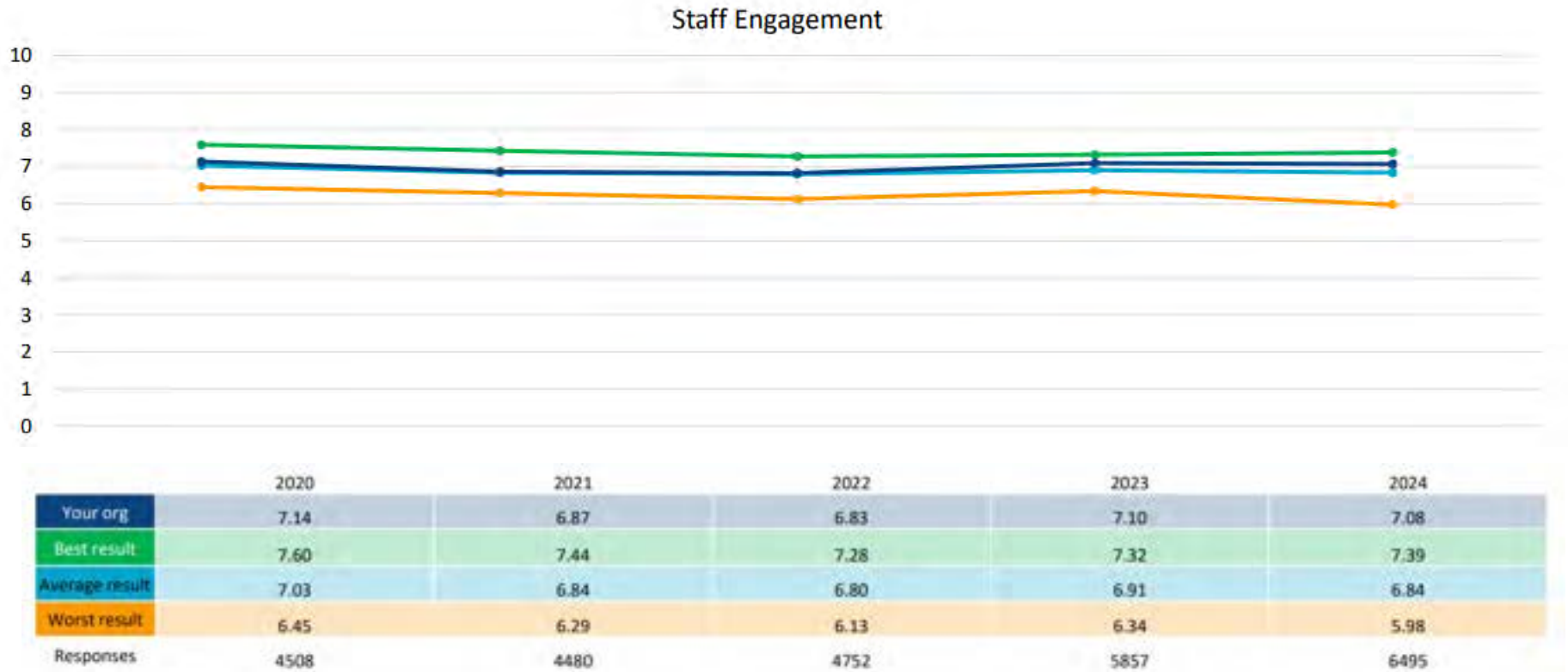
# People Promise Scores and Key Points

- NBT People Promise scores are slightly improved due to larger weighting of National comparator compared to IQVIA comparator scores initially received a few weeks ago.
- All People Promise themes, morale and engagement are above National comparator average.
- All People Promise scores/themes have shown no statistically significant changes since 2023, except for **'We are always learning'** which is classed as significantly higher – 0.17 higher.
- All People Promise scores/themes have shown a slight improvement on scores except for **'Staff engagement'** which has declined slightly by 0.02.
- **We are compassionate and inclusive** - highest scoring PP theme 7.44. Close to comparator best of 7.69 and above average of 7.21 – similar to 2023.
- **We are always learning** – lowest scoring PP theme 5.94. Close to comparator best of 6.09 and above average of 5.64 - similar to 2023.
- Q25d – 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree)' 75.11% – **13.6% better than national average. However, this is a declining trend since 2020, 82.94% - 7.83% worse.**
- Q25c – 'I would recommend my organisation as a place to work (Agree/Strongly agree).' 69.5% – **8.6% better than national average, but 0.8% lower than 2023.**
- Q3i - '*There are enough staff for me to do my job properly*' improved by 4.69%, above 2020 level (35.89%) and 3.93% better than National Average.
- **Your health, wellbeing and safety at work** - Question section with the lowest scores compared to national comparator. 14 out of 43 questions in this section scored lower, which includes most of our worst comparing questions.
- Our lowest comparison score relates to sub question on ethnicity-based discrimination which is 2.2% lower than the National average. This is likely due to patient discrimination.



# Staff engagement

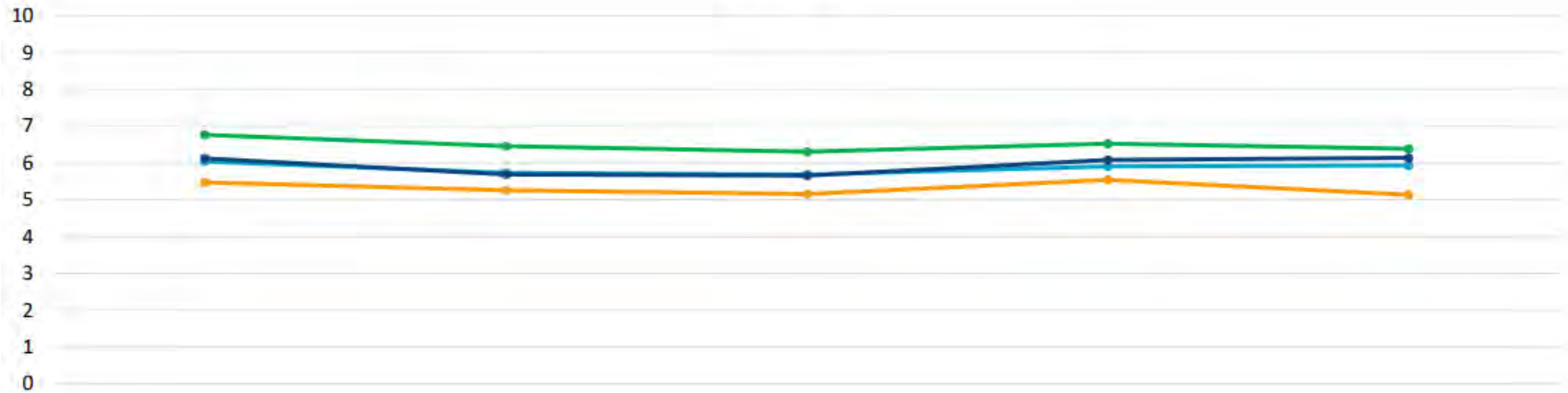
Staff Engagement has declined slightly to 7.08, however, all questions scored higher than the National average.



# Morale

- Morale has improved to 6.14 - highest since 2020 (6.12).
- All questions scored same or better than the National Average across this theme.
- Point of note. 3 questions each on Motivation & Advocacy sub scores are above the National average, however, both NBT and the National average are showing a declining trend since 2020.

Morale



	2020	2021	2022	2023	2024
Your org	6.12	5.69	5.65	6.08	6.14
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	4503	4476	4749	5860	6500

# Divisional People Promise Comparison



Key:

		6.02	6.78	6.27	5.77	6.06	6.80		
			6.88	5.84					6.04
		6.21					7	7.18	6.09
								6.94	

- **Corporates** – scored highest in 8 out of 9 themes.
- **NMSK & Medicine** - each scored highest in 1 out of 9 themes.
- **W&C** – scored lowest in 6 out of 9 themes.
- **Facilities** – scored lowest in 2 out of 9 themes.
- **CCS** – scored lowest with 1 out of 9 themes.
- **Corporates, NMSK and ASCR** equal to or higher than Trust total.
- **Corporates** scored higher than Trust in all themes.

Division	8th	Response Rate	Total People Promise Score (out of 90) 2023	Total People Promise Score (out of 90) 2024	2024 Ranking
		76.42%		62.12	
NMSK			60.81	59.86	2nd
ASCR		56.26%	58.07	59.09	3rd
Medicine					
CCS			57.35		5th
Facilities			58.00	57.97	
			54.91		
NBT		62%	58.46	58.92	

# Occupational Group People Promise Comparison

Key:



				6.71	5.71			7.06	6.31
			6.94	6.00					5.98
			6.71						
								7.19	6.05

- **Add Prof Scientific and Technic** – scored highest in 3 out of 9 themes.
- **AHPs & Estates Ancillary** – scored second highest in 2 out of 9 themes each.
- **Medical & Dental** – scored third highest in 1 out of 9 themes.
- **Healthcare Scientists** – jointly scored lowest in 5 out of 9 themes.
- **Additional Clinical Services, Estates & Ancillary & Nursing & midwifery** – each scored lowest in 1 out of 9 themes.
- **All staff groups scored higher than the Trust total** except for Additional Clinical Services and Healthcare Scientists.

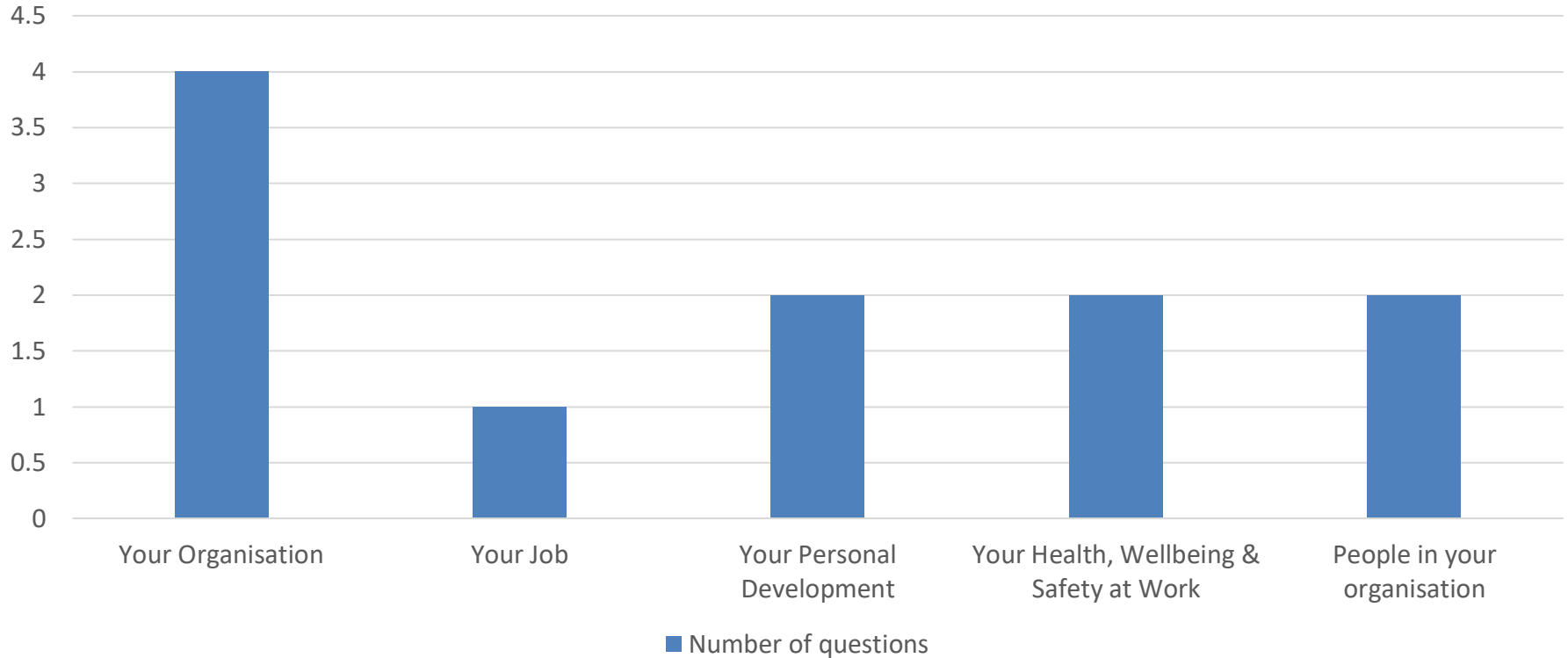
Staff Group	Response rate	Total People Promise Score (out of 90) 2023	Total People Promise Score (out of 90) 2024	2024 Ranking
Administrative & Clerical	75.99%	59.84	60.37	1st
Add Prof Scientific and Tech.	65.80%	58.46	59.81	2nd
AHP	63.05%	56.27	59.75	3rd
Nursing & Midwifery Reg.	62.58%	57.97	58.9	4th
Medical & Dental	42.86%	58.21	58.74	5th
Estates & Ancillary	59.32%	58.07	58.63	6th
Additional Clinical Services	58.46%	58.20	57.58	7th
Healthcare Scientists	63.43%	56.75	55.94	8th
NBT	60%	58.46	58.92	

## Questions scoring significantly better (5% variance) than National comparator average

Q	Question	Questionnaire Section	National Acute & Community Comparator	NBT	Variance
Q25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	YOUR ORGANISATION	61.5%	75.1%	13.6%
Q25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	YOUR ORGANISATION	60.9%	69.5%	8.6%
Q23a	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).	YOUR PERSONAL DEVELOPMENT	85.1%	92.1%	7.1%
Q11a	My organisation takes positive action on health and well-being (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	56.0%	63.0%	7.0%
Q05c	Relationships at work are strained (Never/Rarely).	YOUR JOB	45.9%	52.7%	6.8%
Q24b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	YOUR PERSONAL DEVELOPMENT	54.3%	60.7%	6.4%
Q08b	The people I work with are understanding and kind to one another (Agree/Strongly agree).	PEOPLE IN YOUR ORGANISATION	68.9%	75.0%	6.1%
Q08c	The people I work with are polite and treat each other with respect (Agree/Strongly agree).	PEOPLE IN YOUR ORGANISATION	70.0%	76.0%	6.0%
Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	YOUR ORGANISATION	60.3%	66.0%	5.7%
Q11e	Have you felt pressure from your manager to come to work (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	21.3%	15.9%	-5.5%
Q25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	YOUR ORGANISATION	74.4%	79.6%	5.2%



# Questions scoring significantly higher (>5%) than National comparator average based on question section

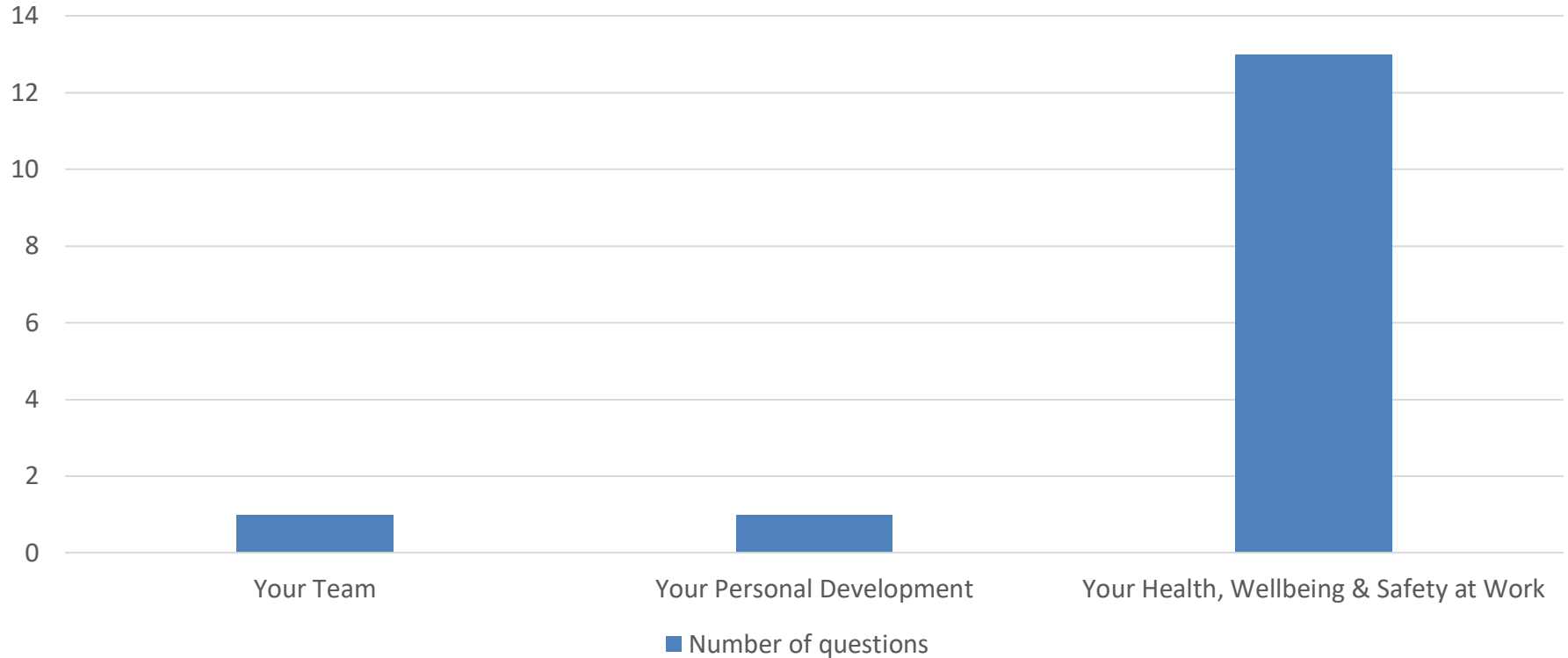


# Questions scoring lower than National comparator average

(NB. No questions scored significantly lower (5% variance) than the average.)

Q	Question	Questionnaire Section	National Acute & Community Comparator	NBT	Variance
Q16c01	On what grounds have you experienced discrimination? Ethnic background (Yes).	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	56.2%	58.3%	2.2%
Q17a	In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public (Yes)	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	8.0%	9.5%	1.5%
Q13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Yes).	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	14.4%	15.3%	1.0%
Q07b	The team I work in often meets to discuss the team s effectiveness (Agree/Strongly agree).	YOUR TEAM	61.9%	61.0%	-1.0%
Q16c02	On what grounds have you experienced discrimination? Gender (Yes).	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	18.5%	19.4%	0.9%
Q11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (Yes).	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	30.3%	31.2%	0.9%
Q12e	How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always)	YOUR HEALTH, WELL BEING AND SAFETY AT WORK	42.5%	43.4%	0.9%
Q23b	It helped me to improve how I do my job (Yes, definitely).	YOUR PERSONAL DEVELOPMENT	25.7%	25.3%	-0.4%
Q19b	My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	86.0%	85.5%	-0.4%
Q16c04	On what grounds have you experienced discrimination? Sexual orientation (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	3.7%	4.0%	0.3%
Q14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	24.7%	25.0%	0.3%
Q16c07	On what grounds have you experienced discrimination? Other (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	22.0%	22.2%	0.2%
Q18	In the last month have you seen any errors, near misses or incidents that could have hurt staff and/or patients/service users (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	35.6%	35.8%	0.2%
Q16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (YES).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	8.8%	8.9%	0.2%
Q13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (Yes).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	1.9%	1.9%	0.1%

# Questions scoring worse than National comparator average based on section question



# Workforce Race Equality Standards (WRES)

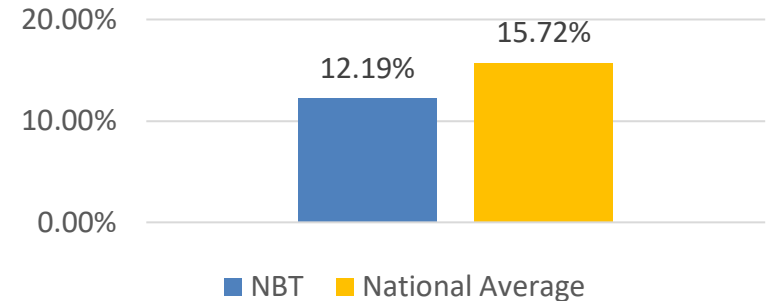


All scores have improved compared to 2023, against Trust results and National Comparator average.

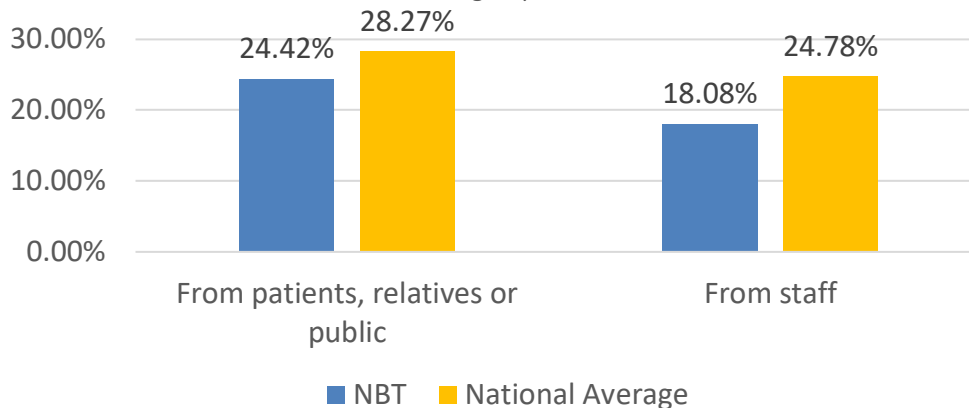
## Results for all other ethnic groups at NBT:

- 4.94% increase in bullying and harassment from patients since 2023 but NBT is 3.85% below National comparator average, which is positive.
- 1.16% decline in Bullying & Harassment from staff since 2023 and NBT is 6.7% below National comparator average, which is positive.
- Career progression: NBT has improved by 2.25% since 2023 and is 1.66% better than the National comparator average.
- Discrimination from staff – 1.65% improvement since 2023 and NBT is 3.53% better than the National comparator average.

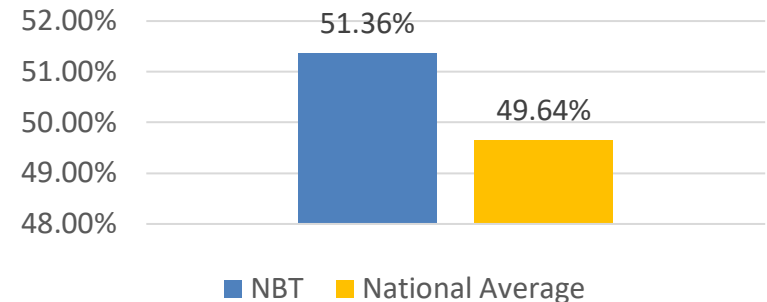
Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months – all other ethnic groups 2024



Percentage of staff experiencing harassment, bullying or abuse – all other ethnic groups 2024



Percentage of staff believing that organisation provides equal opportunities for career progression or promotion – all other ethnic groups 2024



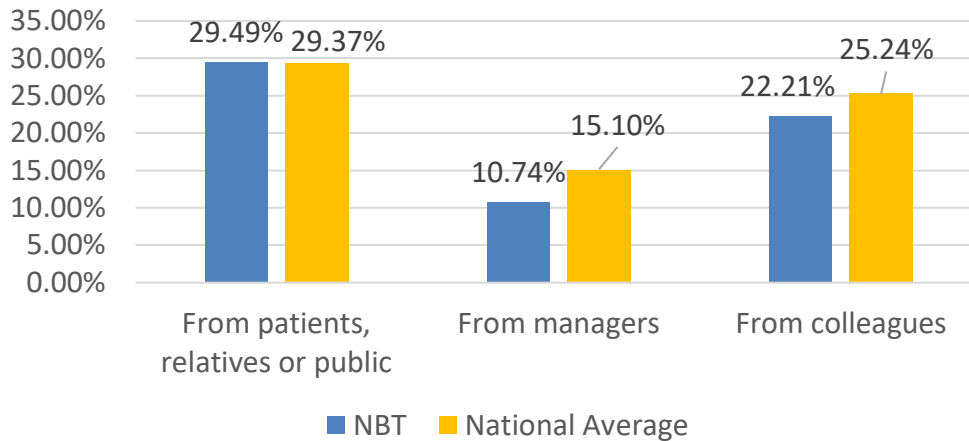
# Workforce Disability Equality Standards (WDES)



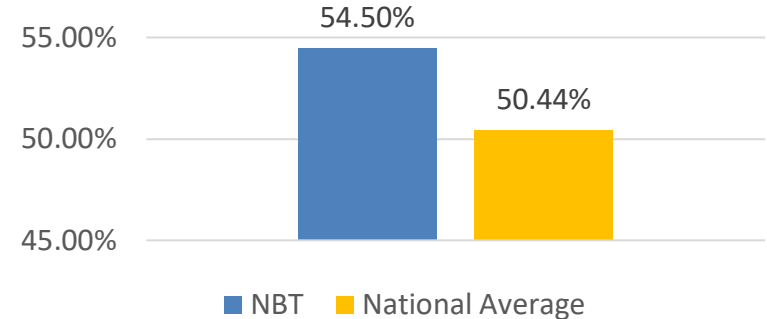
## Results for staff with LTC or Illness:

- Discrimination from managers and colleagues is below average, which is positive and has been decreasing YOY, however, discrimination from patients has increased by 4.36% and is slightly higher than the comparator average.
- Reporting on bullying and harassment improved by 6.73% and is has been improving YOY since 2021. NBT is also better than the comparator by 4.06%.
- Question on career progression declined 0.23% and is slightly below comparator average by 0.2%.

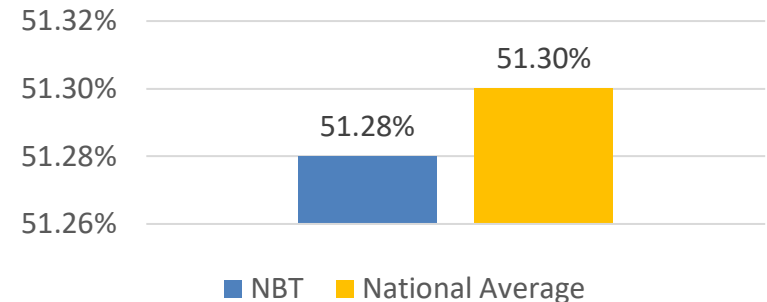
Percentage of staff with a LTC or illness experiencing harassment, bullying or abuse – 2024



Percentage of staff with LTC or illness experiencing harassment, bullying or abuse at work, they or a colleague reported it – 2024



Percentage of staff with a LTC or illness believing that organisation provides equal opportunities for career progression or promotion - 2024





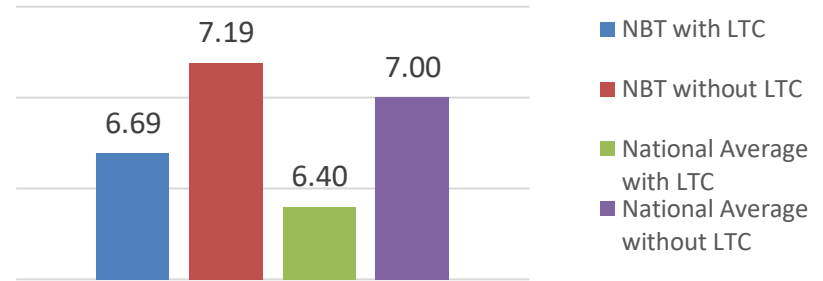
# Workforce Disability Equality Standards (WDES)



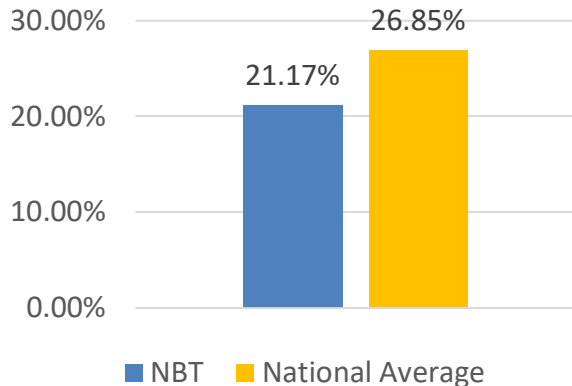
## Results for staff with LTC or Illness, continued:

- **Presenteeism has declined – up 1.19% from 2023 but is 5.68% better than the comparator.**
- **Feeling valued by organisation has improved by 2.7% since 2023 and is 4.85% higher than National comparator average.**
- **Reasonable adjustments declined by 1% since 2023 but is 2.7% above National comparator average.**
- **Employee engagement has improved slightly to 6.69, above comparator average 6.40 but still below trust average 7.06.**

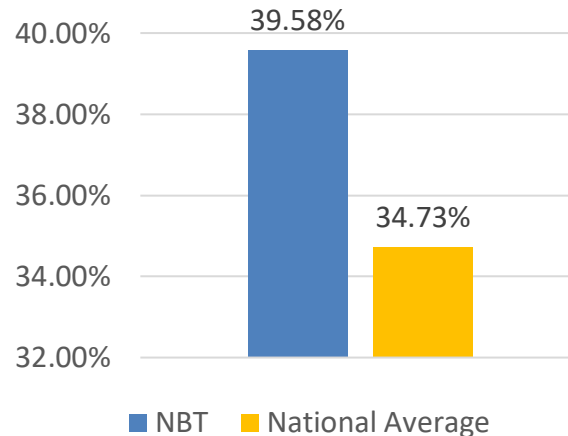
Staff engagement score comparisons



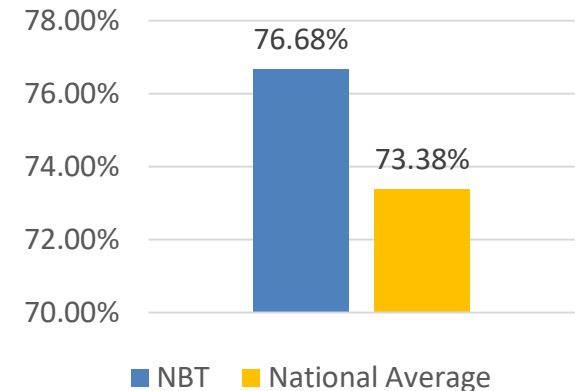
Percentage of staff with LTC or illness who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties - 2024



Percentage of staff with LTC or illness satisfied with the extent to which their organisation values their work - 2024



Percentage of staff with LTC or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work - 2024



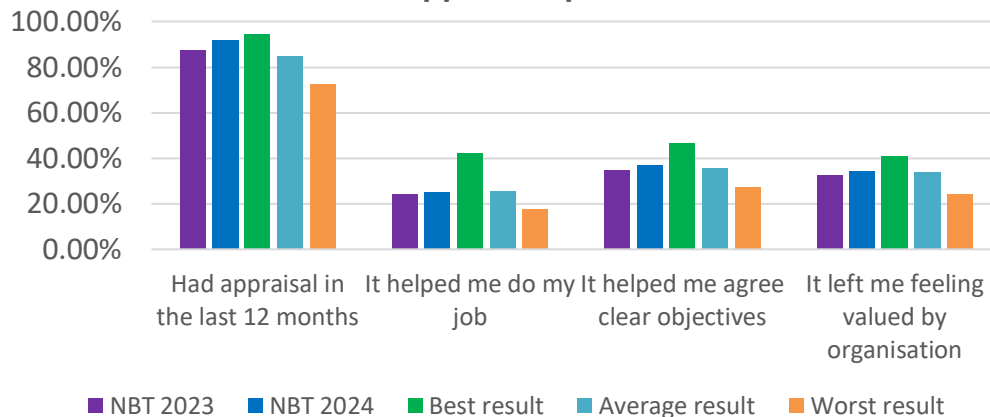
# 2024 - Appraisals

Number of appraisals in past 12 months improved to **92.13%**, up 4.78% higher than 2023 – 18.54% higher than 2020. NBT is also 7.05% higher than National comparator.

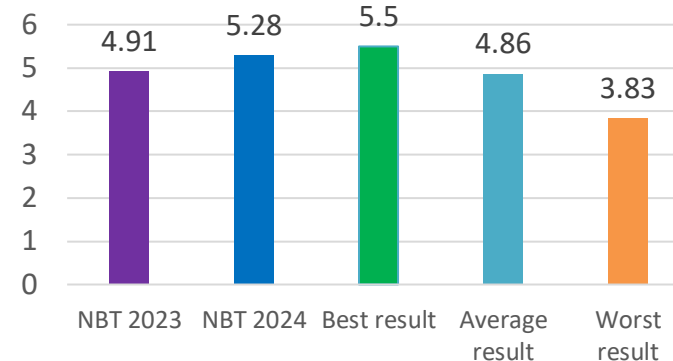
All appraisal questions showed improvement compared to 2023, however, we are still below National average on the quality of appraisals, except for agreeing clear objectives.

- It helped me to improve how I do my job: 8.1% increase since 2020.
- Helped to agree objectives – 8.64% increase since 2020.
- Left me feeling valued. 5.17% increase since 2020.

Appraisal questions



We are always learning People Promise sub-score – Appraisals 2024

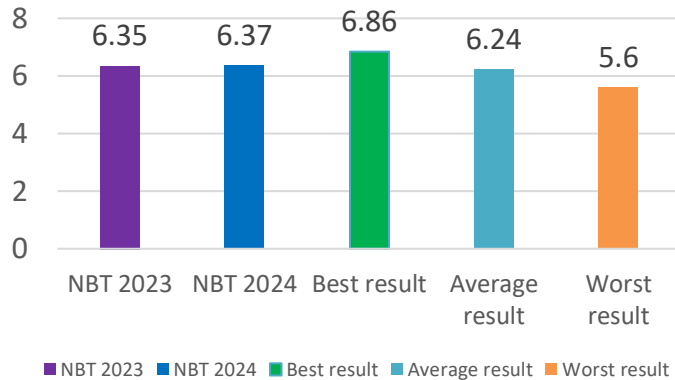


Legend: NBT 2023 (purple), NBT 2024 (blue), Best result (green), Average result (light blue), Worst result (orange)

Global majority staff have scored significantly better than white staff and NBT average for appraisal quality.	NBT	White	Global Majority
Appraisal People Promise sub-score	5.28	4.75	6.55
Q23b - It helped me to improve how I do my job (Yes, definitely).	25.30%	16%	49.3%
Q23c - It helped me agree clear objectives for my work (Yes, definitely).	37.03%	30.1%	54.4%
Q23d - It left me feeling that my work is valued by my organisation (Yes, definitely).	34.26%	28.3%	50.2%

# 2024 – We work flexibly

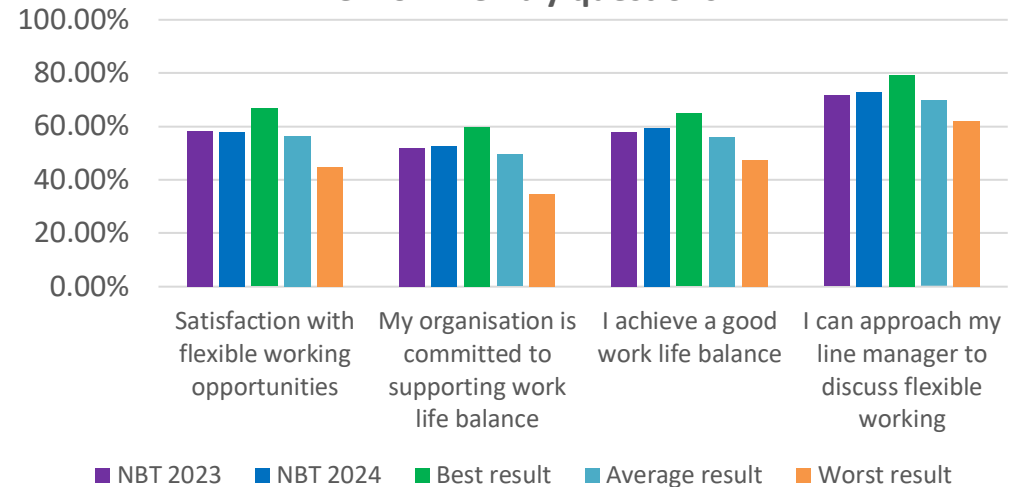
'We work flexibly' People Promise 2024



All flexible working questions have scored higher than the National average.

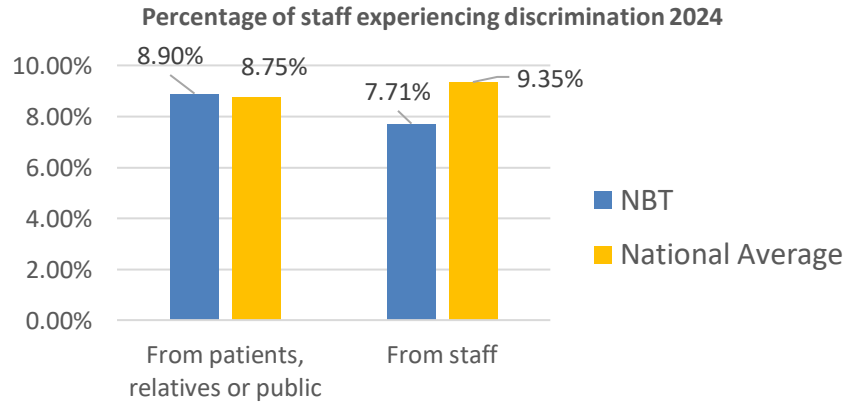
- Q4d – 'satisfaction with opportunities for flexible working patterns' showed a slight decline from 2023 to 2024 of 0.51%, but NBT is 1.33% better than the National average.
- Q6b – 'My organisation is committed to helping me balance my work and home life' improved by 0.54% since 2023 and is 3.13% better than the National average. This question is also 10.05% higher than NBT's 2021 score.

We work flexibly questions



- Q6c – 'I achieve a good balance between my work life and my home life' improved by 1.34% since 2023 and is 3.39% better than the National average. 7.08% better than NBT's 2021 score.
- Q6d – 'I can approach my immediate manager to talk openly about flexible working' improved by 1.37% since 2023 and is 3.23% better than the National average. 7.81% better than NBT's 2021 score.

# 2024 - Discrimination

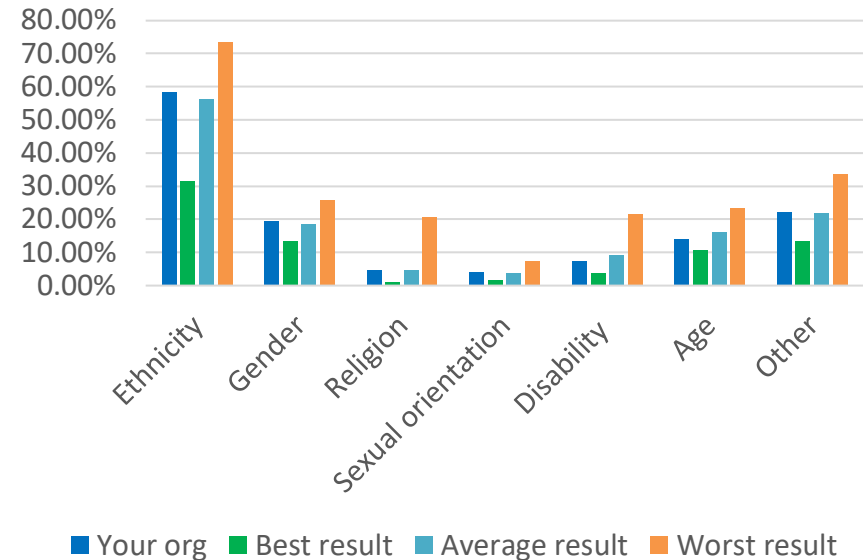


Discrimination at work is **declining from staff**, but **increasing from patients**. Registered nurses and midwives have the highest amount at 14.3% and divisionally, Medicine has the highest with 18.9%.

- ‘Q15 Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?’ - improved by 0.69% since 2023 and better than the national average by 0.01% - 56.03%.

- Q16c1. - **Ethnicity** related discrimination has increased by 2.21% since 2023, showing a worrying increasing trend - **13.07% up from 2020**. NBT is also 2.2% higher than the National comparator average. Registered nurses and midwives had the highest rates across staff groups with **73.3%** and divisionally, Medicine has **66.8%**.

**Grounds by which staff have experienced discrimination 2024**



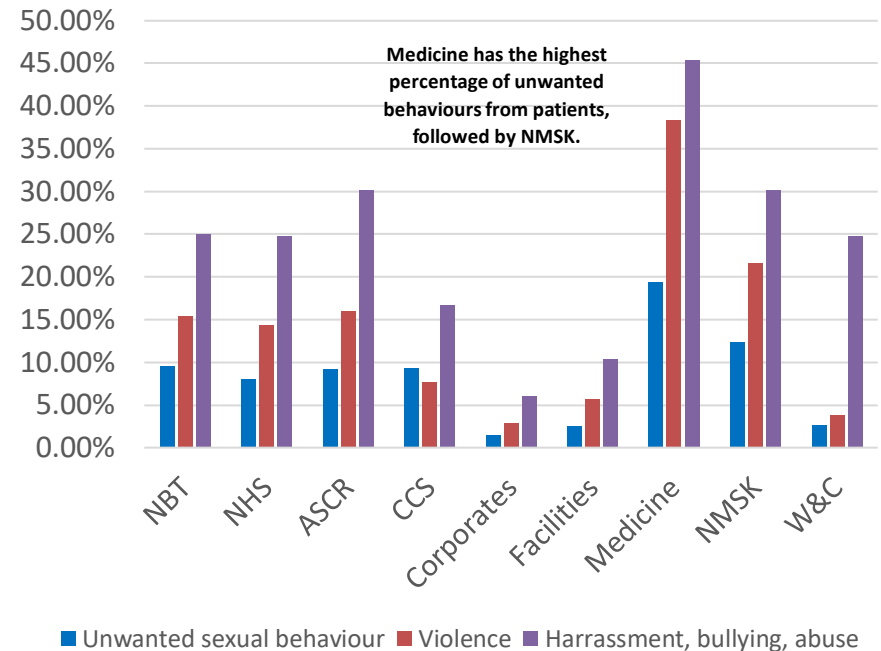
**Ethnicity, Gender, and Sexual Orientation** have all showed a deterioration in NBT since 2023 and in comparison, to the National average.

# 2024 – Staff safety

All but one question relating to experiencing unwanted sexual behaviour or physical violence **from staff** was better than the National comparator average (violence from other colleagues worsened very slightly by 0.05%). However, **all questions relating to unacceptable behaviours from patients were worse than national average.**

- Q13a – In the last 12 months NBT staff experiencing physical violence from service users, their families or members of the public increased by 1.17% since 2023 and is 0.96% worse than the National comparator average.
- Q17a - In the last 12 months NBT staff feeling they were the target of unwanted sexual behaviour from service users, their families or members of the public dropped by 0.32% since 2023. However, NBT was 1.51% higher than the National comparator average and over 12 times the best in group score of 0.76%.
- Staff group with highest percentage of physical violence from patients - Nursing & midwifery 25% (up 0.5% since 2023) and Additional clinical services 25.9% (up 5.2% since 2023).
- Staff groups with highest percentage of unwanted sexual behaviours from patients - Allied Health Professionals 21.8% (up 5.8% since 2023), Additional clinical services 13.8% (up 0.7% since 2023) and Nursing & midwifery 12.9% (down by 2.3% since 2023)
- Unwanted sexual behaviour from staff to staff has declined slightly since 2023 and NBT is below the National average by 0.21%.

## Divisional breakdown for unacceptable behaviours by patients



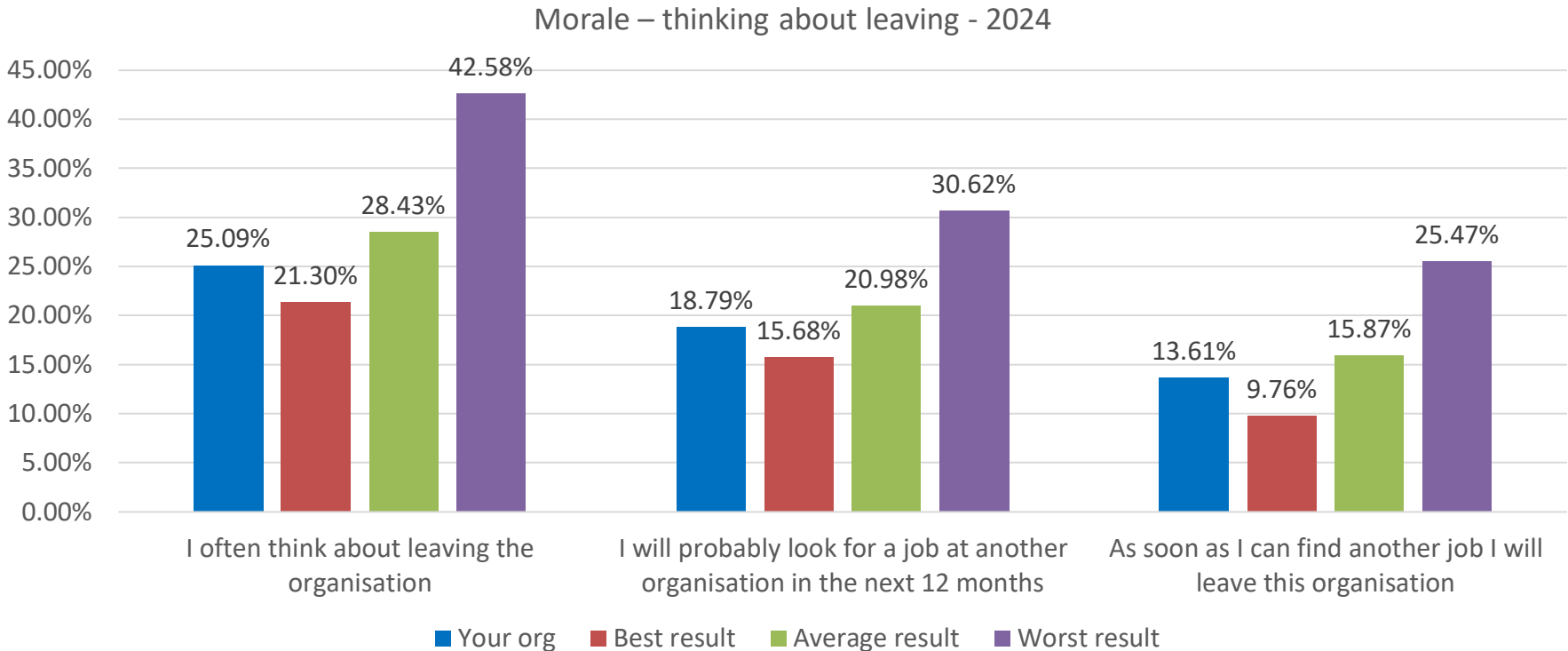
UHBW have scored better than us in relation to unacceptable behaviour from patients.



# Retention Progress

## Overall improved picture on retention and intention leave.

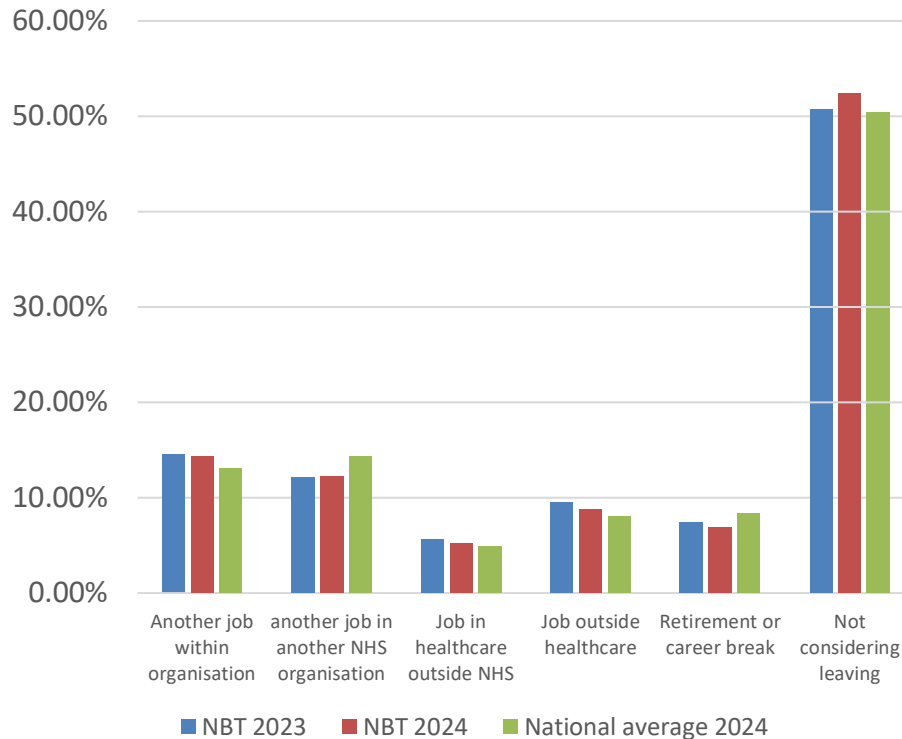
NBT better than average across all 'thinking about leaving' questions, however, 'As soon as I can find another job, I will leave this organisation has deteriorated at NBT by 1.27% since 2023 and nationally by 0.55%.



# Retention Progress

## Overall improved picture on retention and intention leave continued.

Destination if considering leaving - 2024



- 'Thinking about leaving' in the NHS is currently 6.04, compared to 6.31 in 2020.
- 'Not considering leaving my current job' has improved by 1.69% since 2023 and we are better than National comparator average by 2.04%.
- People are more likely to seek another role at NBT, if they are considering leaving their current role. Slightly lower than 2023.
- Moving to another job in healthcare outside the NHS is on a downward trend from 5.61% in 2023 to 5.26%. In 2019 this was 4.14%.
- Moving to a job outside healthcare was down 0.77% to 8.74%. We are slightly worse than the National average on this question by 0.74%.
- Considering retirement or career break is down 0.47% and we are below comparator average by 1.43% which is positive.

# Next steps:

- Trust wide comms and divisional comms from March 13<sup>th</sup> to coincide with data release.
- All results, including regional comparisons published on National Survey website on March 13<sup>th</sup>.
- Action planning is underway in divisions, led by DMTs with support from People Business Partners.
- Bank National Aggregate results to follow in April 2025.

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Research and Development Annual Report to the Board		
<b>Report Author:</b>	Helen Lewis-White – Deputy Director of R&D		
<b>Report Sponsor:</b>	Tim Whittlestone – Chief Medical Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		X	
<b>Key Points to Note</b> ( <i>Including any previous decisions taken</i> )			
<ul style="list-style-type: none"> <li>• Provide assurance to the Board regarding Research Performance and success against key performance indicators</li> <li>• Provide progress report against 2022-27 NBT Research Strategy, including the establishment of robust baselines for areas of future work.</li> <li>• Introduce 2025-2030 Bristol Hospital Group* Joint Research Strategy</li> </ul>			
<b>Strategic and Group Model Alignment</b>			
<p>This report updates the Board on the research undertaken at NBT under the UK Policy Framework for Health and Care Research.</p> <p>R&amp;D is aligned to Patient First, sitting within the Innovate to Improve Pillar, but referencing across all pillars.</p> <p>Finally, the report presents the intention to bring before the Board a Bristol Hospital Group Joint Research Strategy.</p>			
<b>Risks and Opportunities</b>			
<p><b>Risks</b></p> <p>These are reported through Trust Research Group. There are no risks to present to Board.</p> <p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Income through commercial research has increased by 47% since 2022.</li> <li>• A capital grant has enabled improvement works within the Clinical Research Centre. This will allow us to attract and deliver more commercial research.</li> </ul> <p>There are significant opportunities to grow commercial research activity at NBT – opportunities to offer innovative research to patients and opportunities for additional income and savings for the Trust.</p>			
<b>Recommendation</b>			
This report is for Information			

The Board is asked to note the progress against the 2022-27 Research strategy and towards the creation of a Hospital Group Strategy and commend research active staff across the Trust for their commitment, compassion and curiosity to identify better approaches to patient health and wellbeing.

**History of the paper (details of where paper has previously been received)**

[Name of Committee/Group/Board]	[Insert Date paper was received]
---------------------------------	----------------------------------

<b>Appendices:</b>	<i>Nil</i>
--------------------	------------

**1. Purpose**

- 1.1 To provide assurance for the Trust Board on NBT research activity,
- 1.2 Update on progress against the 2022-27 NBT Research Strategy
- 1.3 Introduce the new 2025-2030 Bristol Hospital Group Research Strategy.

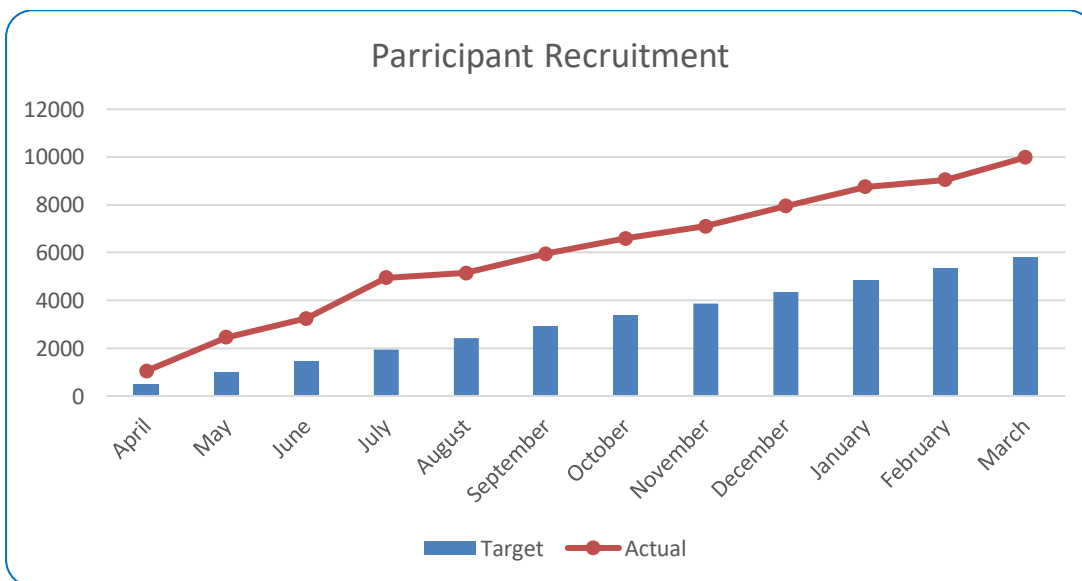
**2. Background**

- 2.1 This paper provides a summary of R&D progress against key performance indicators, the 2022-27 strategy aims and to update the board on progress towards a Bristol Hospitals Group Joint Research Strategy and associated delivery plans.

**3. Research Performance**

**3.1 Recruitment**

While NIHR no longer uses number of research participants to inform its financial allocations, it continues to monitor participant recruitment against recruitment in the 12 months before pandemic, 2019-20. A baseline of 5792 participants into 212 studies is therefore used. In 2024-25, 9981 participants have been recruited into 182 studies.





### 3.2 Recruitment to time and target

Recruitment to time and target is an important metric for research as it provides an early indication if a study is going to be able to answer the question it is setting out to address.

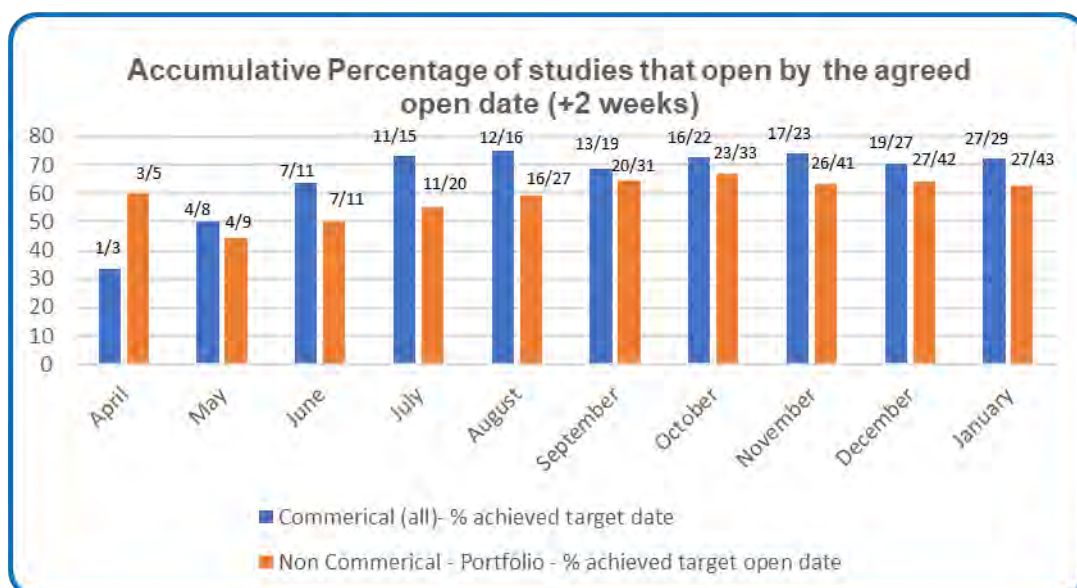
Of the 42 studies that closed at NBT in 2024-25, 76% of studies recruited more than 80% of the study target.



### 3.3 Set up within 2 weeks of agreed start date

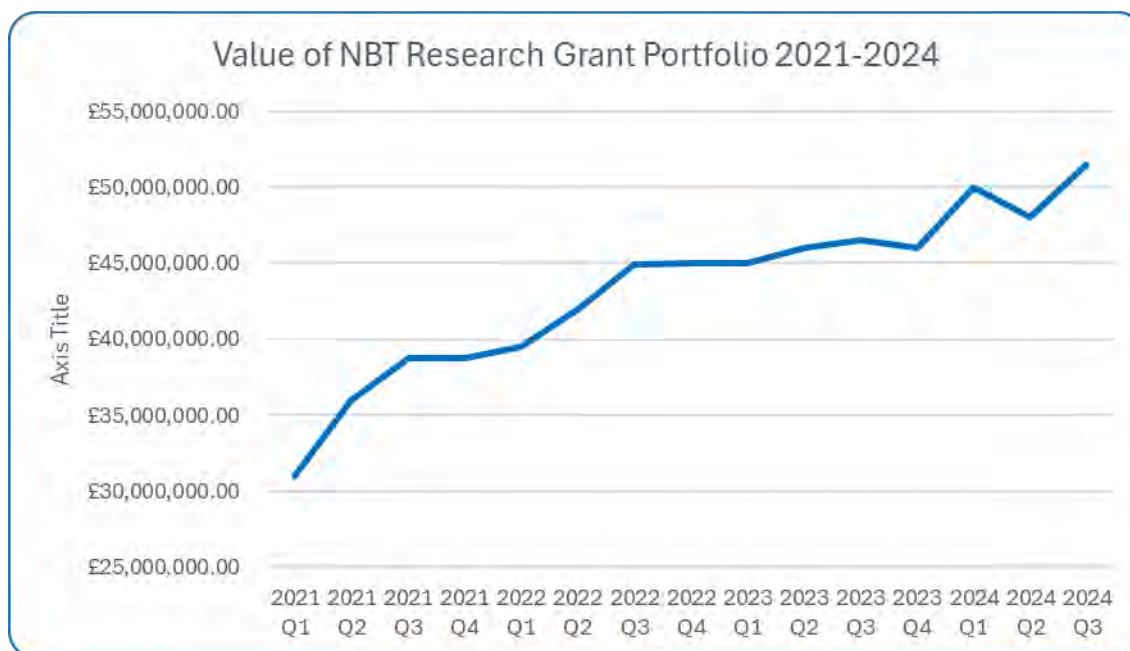
Opening a study ‘on time’ is highly valued by research organisations looking for sites to conduct their research, and it is something that brings them back with their research business. It also makes research available to patients as early as possible and gives us the best chance of recruiting to time and target. Therefore, in April 2024, NBT introduced a metric to issue confirmation of Capability and Capacity within 2 weeks of a start date, mutually agreed between NBT and the study sponsor.

Over the year, for commercial studies, achievement against this metrics has improved from 33% to 71%.



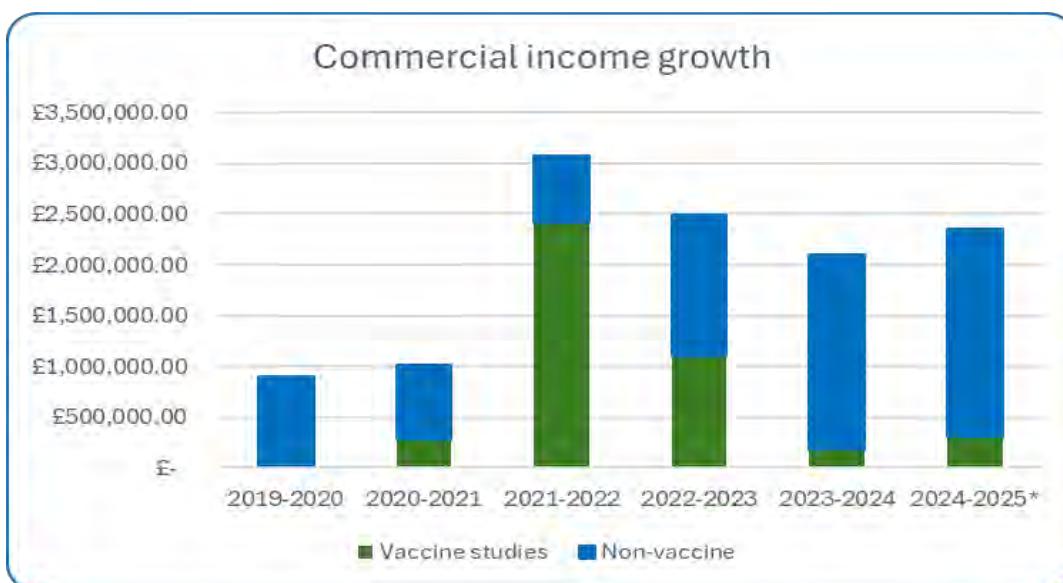
### 3.4 Grant activity and success.

2024-25 has seen another successful year for NBT-led grants. While the majority of this income is pass-through payments it reflects NBT success as a research leader. NBT led the submission of 76 grants in 2024/25, with 82% of full stage NIHR grant submission (n11) awarded, a testament to the expertise of our clinicians, the grant development team, and our successful collaborations with our academic partners.



### 3.5 Commercial Income and activity

NBT has set an ambition to double commercial activity (as measured by income) over a 5-year period from 2022-23. Following the Covid-related spike in commercial research income in 2021-22, income has reduced slightly but remained significantly above pre-Covid levels. Non-vaccine commercial research has doubled since 2019-20 and increased by 47% since 2022-23.



## Performance summary

Against all metrics NBT is demonstrating sustainable growth and improvement placing it in a strong position to compete within the UK Life Sciences market. In addition to income generation through commercial research and seeking to identify optimal care and care pathways for our patients a small number of trials provide treatments which otherwise would have been purchased by the NHS. A pilot project undertaken in early 2025 identified 11 studies where treatment costs for drugs or devices were met wholly or partially by the sponsor. This amounted to a little over £300k in costs avoided. This saving excludes any associated imaging or staff costs. There is great interest in this way of counting the benefits of research activity from other NHS R&D leaders and NIHR.

Further NBT has been awarded £200k to undertake a capital project within the Clinical Research Centre to further enhance our commercial research income opportunities.

## 4. 2022-27 NBT Research Strategy

In 2022 NBT launched the extant NBT research strategy, consisting of four aims and two principles

### 4.1 Principle One: Equity and Inclusivity –

Since 2023/24 R&D has collected ethnicity data with research participants, recording it in over 80% of study participants. (For some studies it is not possible to collect this data.) From this data, 7% of research participants at NBT are from the global majority. This data provides a baseline against which to assess improvements in connecting with populations from the global majority. Bristol council data indicates the global majority represents approximately 16% of our population and therefore provides a target

Positive role modelling, use of media and attendance at preceptorship and induction has seen a change in the demographics within the R&D workforce at band 5 and above, with 15% of research staff from the global majority

It is hoped, and anticipated, greater representation within research staff from the global majority will help start to address study participant recruitment disparities over time.

In addition to equity of access for our participants NBT has been keen to support the development of non-medic researchers. In 2022 NBT launched a dedicated funding and mentorship scheme which has successfully supported a number of successful non-medics to secure NIHR fellowships to support their onward development.

In 2024 the NIHR also released its first RfPB for under-represented professions. This was an extremely competitive call. NBT submitted two applications, both of which progressed successfully to the full stage review, formal outcome notification is awaited.

Given the level of competition for this call NBT should be proud of its achievement in this first round.

### 4.2 Principle Two: Environmental sustainability

In 2024 NBT became the first NHS Trust to become a signatory to the Concordat for the Environmental Sustainability of Research and Innovation Practice. Helping shape how we develop and deliver research in an environmentally sustainable way.

**4.3 Influence and Impact:** The aim of research is to change and improve care and wellbeing of our patients, populations and colleagues.

The graph below demonstrates how research led by NBT as impacted clinical guidelines, care, education, and policy.



## 5. Bristol Hospital Group \* Joint Research Strategy -

Following the publication of the Joint Clinical Strategy and the formation of the Bristol Hospitals Group, the R&D teams at NBT and UHBW set out on a project to co-design a Joint Research Strategy.

The Bristol Hospital Group Joint Research Strategy has been developed with input from both staff at NBT and UHBW and with the support of external stakeholders and has evolved from both Trusts previous separate strategy.

The Bristol Hospital Group Joint Research Strategy will be underpinned by separate delivery plans, one for each Trust. While it is recognised that there will be elements of commonality for both plans maintaining separate delivery plans allows the two Trusts to develop and exploit their respective unique research portfolios.

While the final draft is still in preparation it is anticipated that the new joint strategy will help shape a cohesive approach to the system challenges facing us. The aims / objectives will seek to address the most pressing questions, inspire curiosity across our workforces, be inclusive and sustainable.

## 6. Summary and Recommendations

- 6.1 *We commend the paper to the Board, ask the Board to acknowledge the work of our researchers across the Trust and a strong performance across all indicators.*
- 6.2 *R&D would also like to highlight that only 7% of research participants are currently from the global majority and while disappointing this is the first year we have been able to provide a robust baseline, and considers this a starting point*
- 6.3 *R&D would like to acknowledge that while success within non-medic led research is starting, again, this is a starting point and baseline.*

<b>Report To:</b>	Public Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	South Gloucestershire Joint Health and Wellbeing Strategy		
<b>Report Author:</b>	Tim Keen, Associate Director of Strategy (and NBT representative at the South Gloucestershire Health and Wellbeing Board)		
<b>Report Sponsor:</b>	Tim Whittlestone, Chief Medical Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
		X	
	To engage the Board on the draft strategy and collate feedback for South Gloucestershire Health and Wellbeing Board		
<b>Key Points to Note</b> ( <i>Including any previous decisions taken</i> )			
The South Gloucestershire Health and Wellbeing Board has a statutory responsibility to develop a Joint Health and Wellbeing Strategy and is consulting partners on the new draft strategy for 2025-29.			
<b>Strategic Alignment</b>			
The draft strategy is well aligned to our ICS strategy and NBT's clinical strategy with commitments on: <ul style="list-style-type: none"> <li>- Community involvement</li> <li>- Place-based working</li> <li>- Addressing inequalities</li> <li>- Focus on prevention</li> <li>- Use of data and insights</li> </ul>			
<b>Risks and Opportunities</b>			
The strategy provides an opportunity to focus the Health and Wellbeing Board's effort on shared priorities. The Board provides a platform for partnership working in South Gloucestershire, bringing the key statutory and voluntary organisations together to work on a shared agenda, informed by the strategy.			
There are no explicit risks to NBT. However, the Board should note that the constrained resource envelopes in local public services will make it more challenging to deliver on the vision set out in the strategy. For instance, to improve prevention at scale would require upfront investment and there are limited routes for funding this in the current environment.			
<b>Recommendation</b>			
Board is asked to: <ul style="list-style-type: none"> <li>• <b>Confirm the Trust's broad support of the strategy and the commitments required of partner organisations.</b></li> </ul>			



<ul style="list-style-type: none"> <li>• <b>NEDs are asked to provide any further comments to include in the draft consultation response.</b></li> </ul>	
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>	
<b>Executive Committee</b>	<b>12 March 2025</b>
<b>Appendices:</b>	Appendix 1: <a href="#">Draft strategy for engagement</a> Appendix 2: <a href="#">Draft response to the consultation questions</a>

## 1. Purpose

- 1.1 To inform Board on the draft strategy and take feedback on the consultation questions.

## 2. Background

- 2.1 NBT is a non-voting member of the South Gloucestershire Health and Wellbeing Board (H&WB). Each H&WB has a statutory requirement to set out a Joint Health and Wellbeing Strategy and South Gloucestershire is now consulting partners on the draft 2025-29 strategy.

## 3. Draft Strategy

- 3.1 The strategy is appended ([Appendix 1](#)). The strategy provides:
- a high-level overview of health and wellbeing in South Gloucestershire
  - context of the strategy and wider ICS strategy
  - a clear vision for South Gloucestershire residents and one for health and care partner organisations
  - Describes 5 commitments on:
    - Community involvement
    - Place-based working
    - Addressing inequalities
    - Focus on prevention
    - Use of data and insights
  - Proposes 4 focus areas for 2025-26:
    - Children and Young People
    - Healthy Weight
    - Housing and Health
    - Place-based working and Neighbourhood Health
- 3.2 The strategy is well articulated and aligns well with our NBT's clinical strategy and our ICS strategy. Execs have inputted to the draft consultation response for NBT ([Appendix 2](#)) which raises a few suggestions on:
- To be more specific on the area of inequalities the H&WB is going to focus on making an impact on.

- Potential to strengthen focus on enabling healthy behaviours and reducing risk factors in the strategy alongside focus on the core determinants, with greater clarity on partner contributions across prevention priorities
- To consider tightening the annual focus areas to be more specific and to consider closer alignment with system and national areas of priority, ensuring specific short- and longer-term metrics are developed for these areas
- To consider how marginalised communities experiencing health inequalities will be empowered and enabled to participate as equal partners, including in the publication of this strategy.

#### **4. Summary and Recommendations**

##### 4.1 Board is asked to:

- **Confirm the Trust's broad support of the strategy and the commitments required of partner organisations.**
- **NEDs are asked to provide any further comments to include in the draft consultation response.**



# Joint Local Health and Wellbeing Strategy 2025-29

**Draft for stakeholder engagement, 17 February to 11 April 2025**

# Contents

## Overview of our strategy

### Background

- *About the Health and Wellbeing Board*
- *Working within a wider system*
- *How we work together as a Board*

### About this strategy

- *A new approach for this strategy*
- *Our vision*
- *How we have developed this strategy*

### Our evidence base

- *Current Health and Wellbeing in South Gloucestershire*
- *What local people have told us*
- *Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy*

### What we will do

- *How we will work together*
- *Our five commitments*
- *How we will deliver this strategy*
- *Annual Focus Areas*
- *Working together in a new way*
- *Measuring our impact*

## References

# Overview of our strategy

Our strategy sets out:

- a **shared vision** for the Health and Wellbeing Board 2025-2029
- how the Health and Wellbeing Board can use its **unique role and membership to lead and advocate** for health and wellbeing locally
- a **shared commitment to developing how we work together** to deliver that vision

***Our vision is that South Gloucestershire is a healthy and inclusive place for current and future generations which supports and enables those who need help the most to improve their health the fastest.***

5

**Commitments** *to develop Health and Wellbeing Board ways of working together*

Strengthening community involvement

Building a programme of place-based working

Doing more to reduce inequalities

Shifting upstream with a focus on prevention

Strengthening our use of data & insights in decision-making

+

4

**Annual focus areas** *to drive action*



# Background

# About the Health and Wellbeing Board

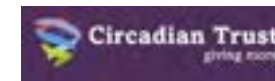


The Health and Wellbeing Board is a statutory committee of South Gloucestershire Council. It brings together senior political, clinical, professional and community leaders from across South Gloucestershire.

The Board aims to reduce inequalities and improve the health and wellbeing of our residents. It works with local partnerships to align strategies, integrate services, and address health priorities through a coordinated, multi-agency approach.

## The Health and Wellbeing Board has statutory responsibilities to:

- Develop a Joint Local Health and Wellbeing Strategy
- Encourage and enable integrated working between health and social care
- Produce a Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment



# Working within a wider system

The Health and Wellbeing Board exists within a system, with many different national and local strategies and priorities already in place.



The South Gloucestershire Health and Wellbeing Board has oversight of the following partnerships:

- Safeguarding Adults Board
- Children's Partnership
- Drug and Alcohol Partnership
- Carers Advisory Partnership
- Learning Difficulties Partnership Board
- Ageing Better Partnership
- Better Care Fund Planning Group
- Health Protection Assurance Group

The Health and Wellbeing Board is responsible for shaping and supporting delivery of the Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy and Joint Forward Plan.

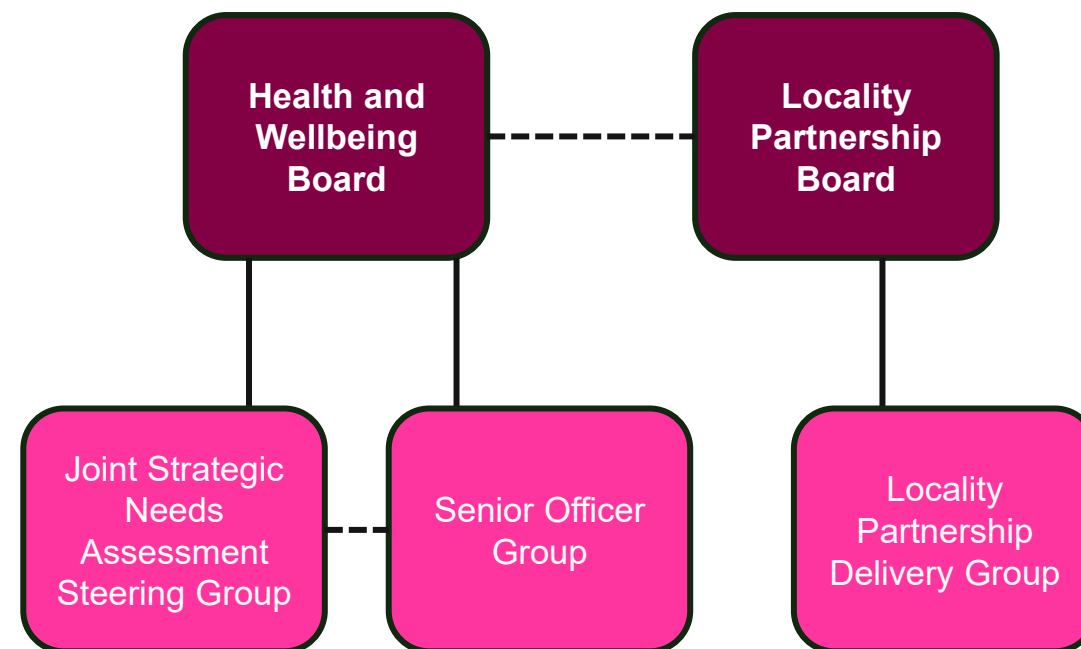
# How we work together as a Board

The full **Health and Wellbeing Board** meets quarterly in public and meetings are webcast. The Board is Chaired by an Executive Member of South Gloucestershire Council.

The **Board's Senior Officer Group** manages the business of the Board, planning the programme of meetings and providing further oversight. The Senior Officer Group is chaired by the Director of Public Health.

The **Joint Strategic Needs Assessment Steering Group** reports to the Health and Wellbeing Board and is responsible for overseeing the Joint Strategic Needs Assessment. This includes supporting the selection and production of needs assessments as well as building skills and confidence among partners to use the findings. This ensures the ongoing production of quality-assured data and insights that inform planning and decisions across the system.

The **South Gloucestershire Locality Partnership** is one of the six locality partnerships within the Bristol, North Somerset and South Gloucestershire Integrated Care Board. It is made up of local health, social care, and the voluntary sector – with citizens and community as equal partners. Our Locality Partnership will be a principal delivery mechanism for this strategy. The Locality Partnership works closely with the Health and Wellbeing Board and the Chair and Director have places on the Board. The Health and Wellbeing Board and Locality Partnership Board meet for quarterly Joint Development Sessions to explore specific topics in greater depth. Other partnerships and groups are invited to join when needed.



# About this strategy



# A new approach for this strategy

This strategy sets out:

- a **shared vision** for the Health and Wellbeing Board over the next four years
- how the Health and Wellbeing Board can use its **unique role and membership** to **lead and advocate** for health and wellbeing locally
- a **shared commitment to developing how we work together** to deliver that vision

## Why have we taken this approach?

**To strengthen delivery of the existing commitments made within the system.** The Health and Wellbeing Board is part of a wider system and works with a wide range of partners, each delivering their own strategies and national priorities. Rather than add a new set of priorities to this system, the Board will strengthen delivery of existing commitments made by and with its partners.

**To develop how we work together in partnership.** For several years inequalities and prevention have been a priority for South Gloucestershire Council, the local NHS and system partners. However, inequalities are still rising, and people are living fewer years in good health. Our communities have also faced significant challenges since the last strategy was written, including the COVID-19 pandemic and the cost-of-living crisis. These have widened inequalities. The Health and Wellbeing Board recognises the excellent work taking place in South Gloucestershire but accepts that we need to develop our ways of working as a system to reverse current trends in health. This strategy is not about inventing new ways of working. It is about strengthening our systems, our partnerships and our communities to improve outcomes for all.

**To work closer with our communities.** A strong message we continue to hear from our communities is that residents want more say over things that affect them and more meaningful engagement. Evidence also shows that involving communities is an important way to reduce inequalities.

**To respond to stakeholder feedback.** Over the last year, the Health and Wellbeing Board has gathered views on what its next strategy should look like. Health and Wellbeing Board Partners told us they wanted to see more support with data and insights and a strategy focus on inequalities, core determinants of health and community involvement.

**To strengthen our use of data and insights in our planning and decision-making.** The Joint Strategic Needs Assessment provides an assessment of the current and future health and social care needs of the local community. It should be used by all partners to ensure that health and care services are designed to meet local needs and resources are targeted effectively. Partners have recognised more could be done to ensure it is fully embedded in decision-making and that its impact is measured.

# Our vision

**For South Gloucestershire residents:**

*South Gloucestershire is a healthy and inclusive place for current and future generations which supports and enables those who need help the most to improve their health the fastest.*

**For the South Gloucestershire health and care system and partners:**

*The Health and Wellbeing Board, its partners and local communities will work closer together to reduce inequalities and hold ourselves to account on our commitments to create a healthier and more inclusive place for all.*

# How we have developed this strategy

**We reflected on the strengths and challenges of the previous Joint Local Health and Wellbeing Strategy**, which ran from 2021-25. It focused on four areas: children and young people, mental health, healthy weight, and the built environment.

**We have developed this strategy in collaboration with system partners.** We have consulted with colleagues from across the health, care and the wider system. We have reflected on the strengths and challenges of the last strategy, our work as a Board, the Joint Strategic Needs Assessment process and local priorities.

**We have used the Joint Strategic Needs Assessment to understand local needs and inequalities.** This strategy is rooted in an understanding of local data and insights. We are committed to an evidence-based approach.

**We are listening to our communities.** The Health and Wellbeing Board recognises that a successful strategy must be based on what is important to local people. This strategy is a response to insights gathered by the Council, Healthwatch and voluntary sector partners.

**We took a creative approach.** Rather than writing another strategy based on previous approaches, we asked partners to share ideas on how to do things differently. We have had honest and challenging discussions about where we have failed in the past and how to make more of a difference as a Board.

**We have focused on developing our ways of working and agreed specific actions to achieve this.** The Board recognised that it could do more with its unique membership to propel local action and strengthen existing commitments made by the health and care system. This strategy sets out concrete actions that aim to develop Health and Wellbeing Board decision-making and partnership working.

**We ran an Equality Impact Assessment** to ensure that our impact on inequalities was positive.

**Our Strategy Editorial Group has wide membership.** This includes representation from across the Council, Locality Partnership, Healthwatch, Southern Brooks Community Partnership and The Care Forum.

## This strategy is based on:

- An understanding of local need and inequality
- Insights from our local communities
- Health and Wellbeing Board self-reflection
- Ongoing engagement with stakeholders
- Equality Impact Assessment

# Our evidence base

**Note: We are reviewing how this information is displayed in the final document**

## Current health & wellbeing in South Gloucestershire

**Delivering for you**

**South Gloucestershire residents tend to have better health outcomes than the national average. But this is not the case for everybody in our community.** Our population experiences higher than average levels of depression and there are significant inequalities in preventable deaths, obesity and alcohol-related illness. We have a growing number of children eligible for free school meals and the educational attainment gap between those with and without free school meals is widening.

**We are seeing a growing number of people living fewer years in good health because of preventable diseases like some cancers, type II diabetes and cardiovascular disease.** The poorest in our society are most at risk of these diseases. We can do more to reduce inequalities by focusing on the modifiable risk factors that drive it.

### Where we are born, live, work and age impacts on our health.

Our environment provides the building blocks for good health. Each block represents one of the essential things we all need to be healthy. We can prevent many diseases and reduce health inequalities by ensuring that these building blocks are in place for all our communities.



Image based on The Health Foundation's Building Blocks of Health  
<https://www.health.org.uk/publications/how-to-talk-about-the-building-blocks-of-health>

**Recent challenges such as COVID and the rising cost of living have widened inequalities.** South Gloucestershire has the most productive economy in the South West, which has contributed to the area's low level of relative deprivation. However, this is not everybody's experience, and the number of local children and families living in poverty is growing.

**Rurality, transport and access to services are sources of inequality.** South Gloucestershire is a largely rural area and access to services can be a challenge. This impacts most on residents without access to transport and those who are less mobile.

**Population changes are likely to further widen inequalities.** South Gloucestershire's population is growing; and ageing faster than the England average. These both present their own challenges, particularly in meeting the increasing demand for infrastructure such as housing, healthcare, education and transport. By 2041 the over-75 population is projected to increase by 11.4%. We are likely to see an increase in residents impacted by caring responsibilities, social isolation, falls, alcohol dependency and poor oral health. In addition, current services are often not located in areas where older people live.

**Climate change will also widen inequalities.** Flooding is identified as the number one risk to the UK from climate change and we have already seen an increase in the number and severity of flooding events impacting the local area. More extreme temperature events and impacts on water security are also expected. Our poorest communities are those most likely to be impacted.



Note: We are reviewing how this information is displayed in the final document.

# Population 299,439



Total population 299,439 in 2023

- FEMALE** 151,250
- MALE** 148,189 (2023 Mid-year estimates)
- CHILDREN (0-15 YEARS)** 53,058 (18.3% of total population)
- WORKING AGE (16-64 YEARS)** 183,172 (63.1% of total population)
- PENSIONABLE AGE (65+ YEARS)** 54,194 (18.7% of total population)
- ETHNIC MINORITY POPULATION** 25,568 (8.8% of total population) (2021 Census)



The total population is projected to increase to 349,239 in 2041 (ONS subnational population projections 2018)

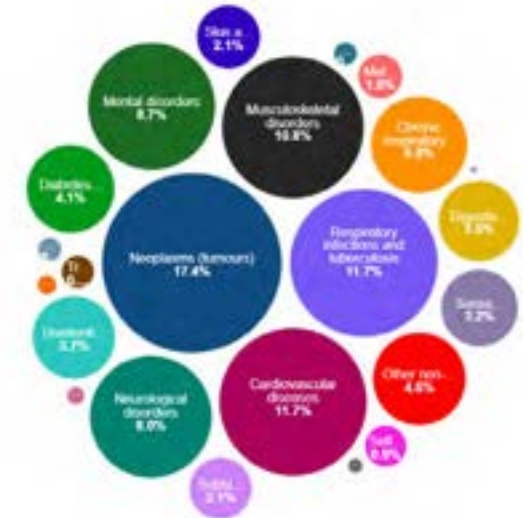
## Headline Statistics

Some key facts about South Gloucestershire



## Burden of disease

Estimates from the Global Burden of Disease Study 2021



Looking at population health data for the whole of South Gloucestershire can mask inequalities at a community level. To understand local inequality, we need to look closer at how multiple factors add together to impact on people's lives.

## Headline inequality statistics



# What local people have told us

We hear a consistent message from local people that they want more say over things that affect them. Many people say they want to be more involved in their communities and how decisions are made. This strategy is rooted in insights from the Council's Community Conversations programme, Healthwatch and our wider local partners. Key themes that have informed our approach to this strategy are set out below.

**Most people agree on what makes life good locally:** a sense of community, access to amenities, and a balance of urban and high-quality rural space.

People **want more say** over the things that affect them, with meaningful upstream engagement not tokenistic consultations

There is a **strong sense of community pride** but it relates more to towns, villages and suburbs than South Gloucestershire as a whole

South Gloucestershire Healthwatch identified three themes about health and social care in 2024 following analysis on insights received:

- **Staff and patient communication**
- **Quality of care and treatment**
- **Appointment availability**

People want a **more adult relationship** with us, alongside more **openness and transparency**

We have heard from children and young people about what is important to them:

- **Positive relationships** with adults
- Having a **wide range of services** that are easily accessible, timely and appropriate
- **Schools that create a positive** supportive environment
- **Positive activities** to support mental health and emotional wellbeing

**If we are going to engage, we need to mean it** (be prepared to change our mind) and **do it well** (blended to suit residents' needs)

**The council and communities are seen as sharing joint responsibility** for making South Gloucestershire a good place to live

There is opportunity to tap into local pride **and facilitate people's relationship** and participation within their place/community

Council consultations on its Inequalities Strategy and Budget identified that important issues for local people are:

- **Health and Wellbeing**
- **Educational attainment and experience**
- **Poverty and financial hardship**



# Integrated Care Strategy on a page

## 5 Opportunities

- 1 We need to tackle inequalities
- 2 We can strengthen the building blocks of good health and wellbeing
- 3 Wherever possible, we need to prevent illness and treat people earlier
- 4 We need to work alongside communities to support healthy behaviours
- 5 And once people are ill, there are conditions that we could manage better

## Our Commitments

Key things that will benefit people across the life course:

-  Invest in the first 1,001 days of life
-  Early identification and support for people experiencing anxiety and depression
-  Support people to be a healthy weight
-  Reducing harm from tobacco
-  Reduce harm from drugs and alcohol
-  Improved prevention, detection and treatment of cancer
-  Tackle cardiovascular disease
-  Better support for people with painful conditions
-  Support for older people towards end of life

## KEY ENABLERS

-  Faster access to care and support for vulnerable groups
-  Use VCSE expertise to identify and support people most at risk
-  Increase our financial commitment to prevention
-  Change our decision making to actively reduce health inequality
-  Recognise and rectify historical injustices
-  Build a workforce who are supported, skilled and healthy
-  Embed trauma informed practice
-  Create a network of volunteer and staff prevention champions
-  Develop community strengths and assets that support everyday health and wellbeing
-  Use purchasing and employment to support better health and wellbeing

The BNSSG Integrated Care System Strategy was developed with input from many people and grown from analysis of local needs including our JSNA, public and staff views and evidence about how best to secure better outcomes.

This new South Gloucestershire Joint Local Health and Wellbeing Strategy will build on and support delivery of the commitments we have made across our health and care system

# What we will do

# How we will work together

This strategy sets out five commitments to develop how the Health and Wellbeing Board makes decisions and works with partners over the next four years.

The commitments will be used as a lens to guide Board discussions and decisions. Any proposal requesting Board approval will need to show how it supports delivery of this strategy.

Attention to these five areas is not new. What is different about this strategy is:

- **We have agreed focused actions to progress each of our five commitments.** These actions are set out on the following pages and will ensure this strategy makes a difference.
- **A refreshed accountability processes** has been developed to ensure we hold ourselves to account.
- **Each year the Health and Wellbeing Board will produce an action plan setting out up to four Annual Focus Areas for the year ahead.** These areas for collective action will be an opportunity to drive forward best practice with local partners and to deliver on strategy commitments. Focus areas will be selected each year in response to local data, insights and wider system priorities. The principles for selecting focus areas are set out later in this strategy.

5

**Commitments** *to develop Health and Wellbeing Board ways of working*

Strengthening community involvement

Building a programme of place-based working

Doing more to reduce inequalities

Shifting upstream with a focus on prevention

Strengthening our use of data & insights in decision-making

+

4

**Annual focus areas** *to drive action*



# 1. Strengthening community involvement

## Why is this important?

### Evidence shows that community involvement has a measurable impact on health outcomes and reducing inequalities.

- Communities in which people are born, live, work and grow have a significant impact on health and wellbeing. For example, experiencing social isolation and loneliness can be as bad for health as risk factors such as smoking (3).
- Communities hold many assets that can be mobilised to promote health and wellbeing. These include friendships, community cohesion, local groups, skills, and knowledge (4). Asset Based Community Development is based on communities identifying and addressing their own problems through the local assets available to them.
- Involving communities is critical for effective place-based working. Asking people what is important to them, working together to design services and taking a person-centred approach ensures that services can meet the needs of diverse communities. This type of approach is called co-production and has been shown to reduce inequalities (4).

### Our communities have told us they want to be involved.

Residents have told us they want to be more involved in their community and have more say in decisions about where they live.

Sirona Care & Health, a social enterprise delivering NHS and local authority funded healthcare services across Bristol, South Gloucestershire and North Somerset, has a team of Wellbeing Leads trained in Asset Based Community Development. Their role includes close working with communities experiencing health inequalities. These include the Gypsy, Roma and Traveller and Chinese communities in South Gloucestershire.

Through the building of trusted relationships with the Gypsy, Roma and Traveller community, the team recognised a high level of health inequality in relation to breast cancer screening. Because of a lack of a permanent address and lower literacy levels among the community, women were not able to either receive or understand letters inviting them to screening appointments. To address this, Sirona's team has worked with the community to develop and roll out sessions to support them to access this care. The design of these has been led by the community, with Sirona acknowledging that members have the knowledge and ideas to make them as effective as possible.

In addition, the team has worked with the Chinese Wellbeing Society – a local organisation led by and serving the Chinese community – to support their access to preventative services for issues such as falls and diabetes. Key to this has been collaboration with “community champions” within the Society who can interpret and communicate this support in a culturally competent way.

# 1. Strengthening community involvement

## What we will do

1. **Establish community involvement as standard practice.** We will ensure projects and updates presented to the Health and Wellbeing Board have been informed by community involvement, wherever possible.
2. **Give equal weight to insights and data.** The Joint Strategic Needs Assessment Steering Group will develop processes to ensure that community insights are a fundamental part of all needs assessments. The Health and Wellbeing Board will promote a culture shift that increases the value given to community insights in discussions.
3. **Develop better mechanisms to share community insights between Health and Wellbeing Board member organisations.** Board members will learn from each other by openly discussing the types of community involvement which have taken place, what worked well, and what could be improved.
4. **Develop a programme of strength-based community involvement to complement Health and Wellbeing Board meetings.** We will develop meaningful ways to involve local communities in the annual programme of Health and Wellbeing Board meetings.
5. **Develop and share accessible intelligence with local communities, where this is needed to support asset-based community approaches.**
6. **Review and refresh Health and Wellbeing documents to ensure that they are accessible for all those that use them.**
7. **Champion community involvement within organisations.** Health and Wellbeing Board members will promote community involvement approaches and share lessons learned within their organisations.

### To be successful, we need to:

- Ensure **community involvement is welcoming** to all residents of South Gloucestershire.
- Build a **better understanding of what children and young people think about health and wellbeing** in South Gloucestershire.
- Recognise that **real co-production and Asset Based Community Development takes time and resources.**
- Ensure **community involvement is meaningful** and leads to change.
- Have **robust processes** to choose the **most appropriate strength-based approach.**
- **Work with our communities** and ensure we **do not pass risk to them** by expecting them to do it all.
- Recognise that **real Asset Based Community Development** work means that we **cannot control the conversation.**

### What change will we see:

- Health and Wellbeing **Board meetings** and **Development Sessions** will be **informed by insights from strength-based community involvement.**
- **Local communities** will have **greater understanding** of what the Health and Wellbeing Board does and **feel able to influence its conversations.**
- **More effective sharing of insights** between Health and Wellbeing Board partners and learning from each others' approaches.
- Health and Wellbeing Board partners will **strengthen the use of community insights to design services.**

## 2. Building a programme of place-based working

### Why is this important?

**Depending on where you live in South Gloucestershire, your experience and needs will be different.** South Gloucestershire is largely rural in area but most of its population lives within the fringe of Bristol. Local approaches developed with communities gain deeper understanding of the variety of local assets and challenges. This helps services meet the diverse needs of residents.

**Evidence shows that place-based working is an effective way to involve communities, tackle core determinants of health, utilise resources and reduce inequalities.** The Fuller Stocktake report highlighted that the most effective ways to improve population health and reduce health inequalities were those that involved partnerships with local communities (5).

**Place-based working is a national priority in England.** The Independent Investigation of the National Health Service in England (2024 Darzi Report) emphasised the importance of local community-focused approaches (6). The Health and Care Act 2022 and NHS Long Term Plan champion the role of Integrated Care Systems, which bring together health, social care, and community partners to deliver services tailored for local populations (7,8). A cornerstone of better integration is the principle of place-based working, which supports local systems to address unique challenges and opportunities within their communities. Over the next 5-10 years NHS England aims for all neighbourhoods to (6):

- Have the NHS and social care working together to prevent people spending unnecessary time in hospital or care homes
- Strengthen primary and community-based care to enable more people to be supported closer to home or work
- Connect people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

**Our communities and local stakeholders say they want to work more in this way.** A strong theme from community insights is that residents want more say over things that affect them.

**Frontline professionals, including GPs and local voluntary sector partners, are already at the heart of this work.** Health and Wellbeing Board partners and stakeholders have a deep understanding of what is needed to improve the support and care they give in their local areas. Bottom-up approaches are more likely to succeed when engaged local professionals design solutions to meet local challenges. Many Health and Wellbeing Board partners are already leading local efforts and have shown their support for a shift towards more local approaches.

**“Place” can be defined in many ways and does not mean the same thing to all people.**

Our approach to place-based working in South Gloucestershire will be based around how residents define their local neighbourhood and communities. This may include approaches based around where people live, where they go or shared interests and activities.

### Features of place-based approaches



## 2. Building a programme of place-based working

### What we will do

1. **Work with partners to develop a shared vision around what place-based working means in South Gloucestershire, based around how residents define their local neighbourhood and communities.** We will support the Locality Partnership to lead a conversation on Place with communities and local partners.
2. **Support the Locality Partnership-led programme of work around Place.** In Spring 2025, the Locality Partnership launched a new bottom-up approach to place-based working in South Gloucestershire. Communities, frontline professionals, the voluntary sector and local providers are at the heart of planning and local leadership. The Health and Wellbeing Board, Council and Locality Partnership colleagues will act as enablers.
3. **Foster a culture that recognises the unique challenges and opportunities of place-based working.** We commit to place-based working as a long-term approach that requires investment and trust in our communities.

### To be successful, we need to:

- Establish a **shared understanding** of what we mean by place-based working.
- **Involve local communities** in an ongoing and meaningful way.
- **Recognise different approaches may be needed** in different areas and we may see progress at different speeds across South Gloucestershire.
- **Take an iterative approach.** We may fail at first in some places, but we will reflect on challenges and build back better.
- Ensure that all our **partners buy into this approach**
- Recognise that **frontline professionals and volunteers are central to this work.**
- **Learn from good practice elsewhere.**

### What change will we see:

- Communities will become **more engaged** in their health and wellbeing.
- Services and support will be **better able to meet diverse local needs.**
- We will have a **more sustainable Voluntary, Community and Social Enterprise sector** based around place.
- We will shift towards a **more holistic approach to health and care** and will be doing more to tackle core determinants of health.
- **We will use resources more efficiently.**
- We will **improve health outcomes for all and reduce local inequalities** in the longer term.

# 3. Doing more to reduce inequalities

## Why is this important?

### Evidence shows tackling inequalities is essential for:

- **Enabling the best start in life.** The first 1,001 days of someone's life are considered critical for shaping future wellbeing (9). Addressing inequalities and barriers during this time can help to break the cycle of poverty and disadvantage, allowing societies to improve outcomes for children, regardless of their background.
- **Building a strong economy.** Reducing inequalities in health enables greater workforce participation, boosts consumer spending, fosters innovation and entrepreneurship, and reduces health and social care costs (10).
- **Using limited resources efficiently and fairly.** Some of the best ways to reduce inequalities are to tackle the core determinants of health, reducing the downstream costs of treating disease (11). Proportionate Universalism is a recommended approach to allocating resources fairly (15). This method addresses inequality through a combination of universal and targeted interventions, delivering services at a scale and intensity proportionate to need.

**Reducing inequality aligns with national and local priorities.** A local commitment to reducing inequality is set out in the South Gloucestershire Council Plan, and Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy and Joint Forward Plan (12-14). National ambitions to reduce inequalities are set out in the 2024 Darzi Report and 2020 Marmot Review (6,15).

**Tackling inequality is a statutory duty for the Health and Wellbeing Board.** Previous Joint Local Health and Wellbeing Strategies recognised the importance of inequality by addressing it as a cross-cutting theme. Our partners and the Board have reflected that this approach did not always lead to specific action; and it was hard to measure our impact. This strategy commits to doing more to reduce inequalities, setting out specific actions for the Board and a new process to monitor progress.

## Our local picture

**Inequalities in South Gloucestershire are complex.** Health is shaped by multiple overlapping factors such as race, income, education, age, ability, sexual orientation, immigration status, ethnicity, and geography. Each individual experiences a different combination of advantages and challenges related to these factors.

**Inequality is hidden if we look at risk factors in isolation.** Historically, approaches to measure inequality have used simple metrics like income and ethnicity separately. Data for the whole of South Gloucestershire, focused on single risk factors can mask the inequalities experienced by individuals and communities. To understand local inequality, we need to look closer at how multiple factors add together to impact on people's lives.

### For example, in South Gloucestershire:

- Younger white mothers in more deprived areas are less likely to breastfeed their babies (16)
- Men over 50 and with poor mental health are more likely to be dependent on alcohol (17)
- Children who are leaving care and who are from minority ethnic groups are more likely to be 'Not in Education, Employment or Training' (18)



# 3. Doing more to reduce inequalities

## What we will do

1. **Promote a consistent and shared narrative about local inequalities within the Board and among partners.** All Board members and Health and Wellbeing Board partners will be able to describe inequalities in South Gloucestershire.
2. **Foster a culture where reducing inequalities is everyone's business.** We use an inequalities lens in all our discussions as a Board. Health and Wellbeing Board members will act as champions for reducing inequality within their organisations.
3. **Promote proportionate universalism as the recommended approach to allocating funding to reduce inequality in South Gloucestershire.** Whenever the Board discusses a universal service, it should ask what is being done to ensure the service is not widening inequalities.
4. **Develop a support offer for partners to increase engagement with the Joint Strategic Needs Assessment process.** The Joint Strategic Needs Assessment Steering Group will work with partners to develop ways to support better use of data and community insights to identify need and help target resources.
5. **Support the South Gloucestershire Tackling Inequalities Plan 2024-28.** The Health and Wellbeing Board shares the ambition set out in this plan to 'take a proactive, action-based approach to tackling inequalities'. We will monitor progress against delivery of the health and wellbeing objectives set out in the Tackling Inequalities Plan.

## To be successful, we need to:

- **Recognise that action to reduce inequalities takes time.** National trends show that inequality has been rising over time, meaning that the process of addressing it is challenging. Sustained longer-term efforts are needed. We may not see a reduction in local inequalities within the timeframe of this strategy. However, we can measure the changes in service provision and action on core determinants that we expect will reduce inequalities in the longer term.
- **Recognise that reducing inequalities goes hand in hand with prevention and tackling core determinants of health.**
- **Use data and insights to understand the complexity of local inequality and identify where to target resources.**
- **Take a life-course approach,** recognising the importance of the first 1,001 days

## What change will we see:

- The Health and Wellbeing Board will have a **stronger understanding of how need is being addressed** via a strengthened Joint Strategic Needs Assessment accountability process and greater use of local insights.
- **Our communities will feel more involved in shaping services.** Local services will be better designed to meet the needs of our diverse communities.
- **Residents will report higher reported satisfaction** with support received.
- We will **reduce inequality in health outcomes** in the longer term.

# 4. Shifting upstream with a focus on prevention

## Why is this important?

### Evidence shows that:

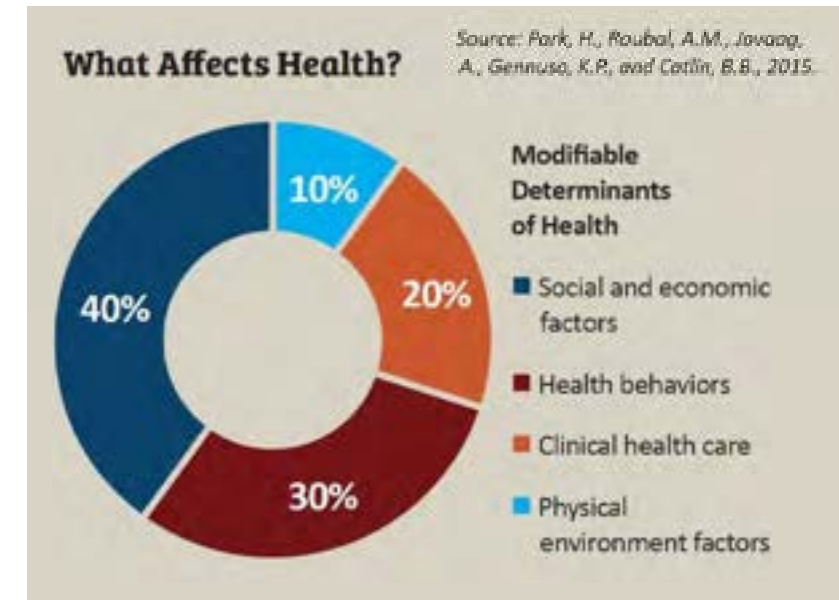
- **A system focus on prevention is essential for improving population health and wellbeing.** Early intervention to tackle the risk factors that cause disease enables people to live longer in good health (6). Staying healthy helps individuals to remain independent and active in their community. This in turn supports wellbeing.
- **Prevention is an effective way to reduce inequalities.** Preventable diseases are disproportionately experienced by some groups (11). For example, cardiovascular disease is among the largest contributor to health inequalities, accounting for one-fifth of the life expectancy gap between the most and least deprived communities (19). Action to tackle risk factors for major preventable disease is an important way to reduce health inequalities.
- **Action to tackle the core determinants of health can have the greatest impacts.** Many health inequalities stem from social inequalities such as inadequate housing, limited access to nutritious food and poverty (6). Social and economic factors account for 40% of the modifiable determinants of our health (20). Healthcare contributes only about 20% and yet the bulk of current health spending goes to health services.

**South Gloucestershire has an ageing population with declining healthy life expectancy.** We are seeing increasing rates of long-term conditions, disability and multiple conditions. People are living longer but spending fewer years in good health. The numbers requiring support and services continues to rise.

**Rates of preventable conditions such as obesity, diabetes, heart disease and some cancers are increasing.** These illnesses can be prevented with lifestyle changes and early intervention, yet they remain leading local causes of disease and death. These diseases often require long-term management which places significant strain on services.

**The health and care system is unsustainable unless we do something differently.** Without comprehensive action to prevent ill health, the pressures on health, care and other public services will only increase.

**Focusing on prevention aligns with national and local priorities.** Many national and local reports set out a commitment to prevention (6,12-14). However, it is widely recognised that prevention has repeatedly been given less attention than more immediate pressures on the NHS and care.



# 4. Shifting upstream with a focus on prevention

## What we will do

1. **Involve young people.** The Health and Wellbeing Board will create opportunities to hear from young people in South Gloucestershire and build their insights into decision-making. This will include collaborating with the Youth Board around how to enable young people locally to live healthier lives.
2. **Ensure that discussions around prevention include action to tackle core determinants of health.**
3. **Commit to allocating long-term resources to early intervention and prevention activities in communities to ensure that core determinants of health are addressed before health deteriorates.**
4. **Support alternative prevention-focused funding models.** The Health and Wellbeing Board will support efforts to develop new funding models that give longer term support to community prevention projects.
5. **Commit to support the workforce and volunteers across our partnership to help them to achieve good health and wellbeing.**
6. **Foster a culture where prevention is everyone's business.** Health and Wellbeing Board members will be encouraged to be directly involved in community prevention projects, for example by signing up to mentoring young people in care.

### To be successful, we need to:

- **Remember to focus on Core Determinants of Health.** Prevention efforts can easily focus only on preventing deterioration for someone with a disease (secondary prevention). Action on core determinants addresses the root causes of ill health and helps reduce inequalities.
- **Collaborate across the system.** Health and Wellbeing Board members have varying degrees of influence over the core determinants of health. At each level of the system there is potential to shift our focus further upstream.
- **Be creative.** We can learn from innovative approaches in other areas and create longer-term sustainable funding models for community prevention programmes.
- **Recognise that increasing prevention is fundamental to reducing inequalities**

### What change will we see:

- **Young people and communities getting more involved in shaping health and care services** to address the core determinants of their health and wellbeing.
- **Measurable shift in spending upstream** among partner organisations.
- **Measurable shift to more person-centred and place-based approaches** to health and care that tackle core determinants of health.
- In the medium to long-term we hope to see **improved health and wellbeing outcomes and a reduction in health inequalities.**

# 5. Strengthening our use of data & insights in decision-making

## Why is this important?

### Robust use of data and insights is crucial for tackling inequalities and targeting need.

The primary mechanism for the Health and Wellbeing Board to understand its population and respond to the needs of communities is through the effective development and use of the Joint Strategic Needs Assessment.

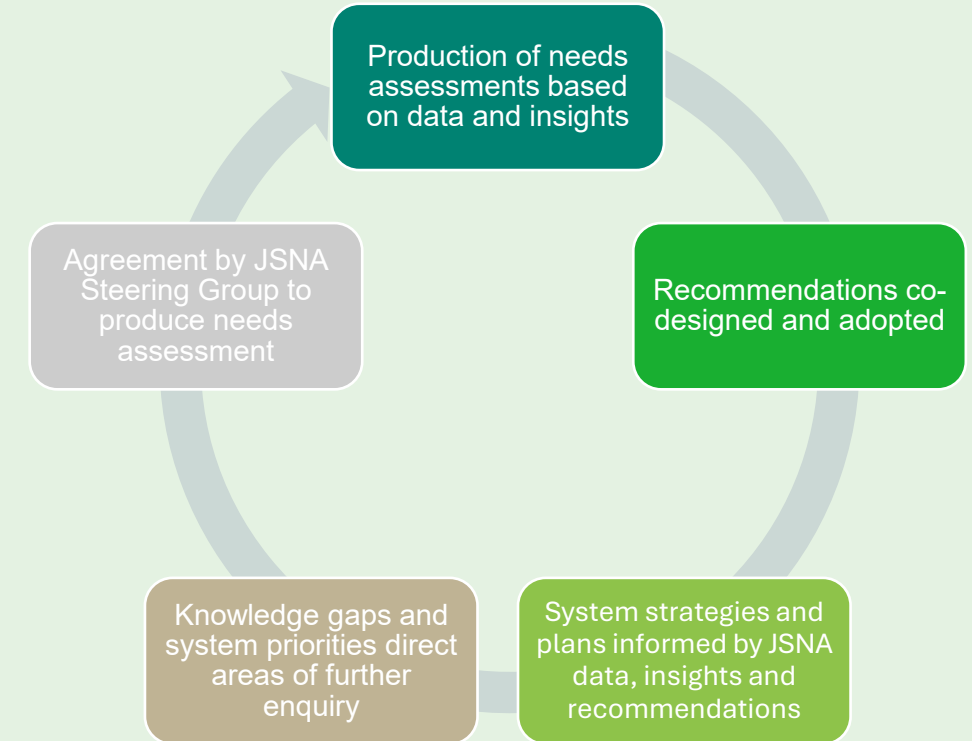
The Joint Strategic Needs Assessment is a statutory duty of Health and Wellbeing Boards. It is defined as “a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed priorities for action that will improve health and wellbeing outcomes and reduce inequalities.”

In South Gloucestershire, the Joint Strategic Needs Assessment Steering Group produces the Joint Strategic Needs Assessment on behalf of the Board. This work includes production of high-level population health dashboards, tools and detailed needs assessments.

### Feedback has identified opportunities to strengthen this process:

- Stakeholders have told us they want more support to use the Joint Strategic Needs Assessment.
- There are opportunities to strengthen how the rolling programme of needs assessments is based on the priorities of partner organisations.
- Partners have recognised more could be done to ensure the data, insights and recommendations of the Joint Strategic Needs Assessment are taken forward by partners.
- Our stakeholder engagement identified opportunities to strengthen how we hold ourselves to account as a Board.

Using data and insights to shape services and inform decision making through the Joint Strategic Needs Assessment (JSNA)



# 5. Strengthening our use of data & insights in decision-making

## What we will do

1. **Strengthen partner engagement with the Joint Strategic Needs Assessment development process**, ensuring comprehensive membership to the steering group.
2. **Support partners to improve their use of Joint Strategic Needs Assessments** to inform decisions. Require more regular updates on new developments and demonstrations on how to use the tools.
3. **Require that any proposal brought to the Board demonstrates how it has been informed by the Joint Strategic Needs Assessment.**
4. **Commit to regular review of how well the Board uses data and community insights to inform decisions.**
5. **Commit to monitoring strategy progress throughout its lifetime.** The monitoring process must be light-touch but robust. We will build in opportunities for reflection and iteration of our approach.
6. **Use quarterly Joint Development Sessions to plan and monitor progress of Health and Wellbeing Board Annual Focus Areas.** Each session will focus on one of the Health and Wellbeing Board focus areas. The session will include a review of plans and progress against the five Health and Wellbeing Board commitments.
7. **Produce a Health and Wellbeing Board Annual Report** that it is relevant and accessible to communities and celebrates new ways of working.

## To be successful, we need to:

- **Foster an open and honest learning culture.** We will actively encourage Board members and partners to share any challenges they have faced so we can work together to find creative solutions.
- **Ensure that self-reflection is not a one-off event** and that we continue to monitor the Strategy throughout its lifetime.
- **Recognise that our monitoring process should be iterative.** We may need to adapt what we measure in response to what we learn.
- **Ensure there is analytical resource and partner commitment** to deliver the new process for improving accountability.

## What change will we see:

- Health and Wellbeing Board is **assured that the Strategy is making a difference.**
- Health and Wellbeing Board is **assured that data, insights and recommendations from the Joint Strategic Needs Assessment inform decision-making.**
- **Joint Strategic Needs Assessment outputs reflect partner priorities** better.
- Decisions and local commissioning are more evidence-based. **Partners are more confident in their use of data and community insights to inform decision-making**
- **Resources are better targeted at need** which will reduce health inequalities.



# How we will deliver this strategy

The strategy runs from 2025 to 2029. We will publish an action plan for each year of its life and use a new accountability process to monitor progress. This will ensure that the Joint Local Health and Wellbeing Strategy continues to drive action throughout its lifetime and adapts when needed.

**Each year, we will identify up to four Health and Wellbeing Board Annual Focus Areas for the year ahead.**

This will ensure that the strategy drives tangible action against its core commitments. These targeted areas for collective action will be chosen during an annual review of the strategy and published in an action plan. Focus areas will be selected each year in response to local data, insights and wider system priorities. They may be iterations of previous focus areas or new priorities for the system.

**We will monitor progress of the strategy throughout its lifetime.** We will monitor our impact using health and wellbeing outcomes, community insights and reports from members and partners on how they have developed ways of working.

**Our new accountability process will include opportunities for ongoing reflection and iteration within the full meeting cycle of the Board.** We will theme each of our quarterly Joint Development Sessions around one of that year's focus areas, using the time to review plans and progress with partners. The Senior Officer Group and full Board meetings will take forward these discussions to ensure continuous learning and to drive action.

**We recognise that we may need to adapt this strategy and our actions in response to what we learn.** We will use our strengthened approach to community involvement to get ongoing feedback from our communities on how the strategy is making a difference for local people.

**We will publish a Health and Wellbeing Board Annual Report** which will summarise strategy progress, celebrate successes and set out plans for the year ahead. We will share accessible and relevant updates with our communities.

## Principles for selection of Health and Wellbeing Board Annual Focus Areas

They should:

- Target local need identified in the Joint Strategic Needs Assessment
- Offer opportunity for the Health and Wellbeing Board to deliver on its five commitments
- Be able to benefit from Health and Wellbeing Board support to drive progress
- Be focused and achievable within a 12-month period
- Be the next development of previous Health and Wellbeing Board focus areas OR a new policy priority which requires system leadership
- Be local, system or national priorities

# Annual Focus Areas

The Health and Wellbeing Board will have up to four focus areas each year to drive action

## Year 1 (2025-26) Proposals:

*To be confirmed following stakeholder engagement*

Children and Young People – to encompass the first 1,001 days of life, education attainment and school attendance

Healthy Weight – to include supporting people to have a healthy weight and sign up to the new BNSSG Healthy Weight Pledge

Housing and Health – housing is an important core determinant of health and there is potential to explore the development of a Health and Wellbeing Board led housing strategy and link into the Ageing Well workstream

Place-based working and Neighbourhood Health - this aligns with Commitment 2 in our strategy, national policy about neighbourhood working and our direction of travel to move care closer to home and integrate local services

# Working together in a new way

Core to the success of the strategy will be Health and Wellbeing Board member commitment to fostering the right culture. The Board has many strengths, including an engaged membership with breadth and depth of experience. Our new strategy seeks to build on these strengths and develop our ways of working. We will have the greatest impact if we are prepared to challenge ourselves and our partners to do things differently.

We are committed to:

- **Open and honest conversations** that identify challenges and opportunities to do things differently
- Acting as a **critical friend** within our partnerships
- A culture of **ongoing reflection and iteration**
- **Leading by example** and acting as ambassadors within our own organisations on behalf of the Health and Wellbeing Board
- **Creativity**
- **Long-term vision**
- Being **evidence-based**
- Reaching and **hearing from all parts of the community**
- Making our meetings and documents more **accessible**



Image to follow

# Measuring our impact

We are committed to monitoring progress of this strategy throughout its lifetime.

To understand the impact of the strategy we will:

- **Develop our own self-assessment tool** to reflect on our work as a Board. This will include a review of how well we use data and insights to inform decisions and how we have developed ways of working in response to this strategy. We will run the tool each year.
- **Ask members and partners to report back** on how they have developed ways of working in response to this strategy.
- **Use our community involvement** work to understand the impact of the strategy for local communities.
- **Use quarterly Joint Development Sessions** to monitor progress of our Annual Focus Areas.
- **Use the Joint Strategic Needs Assessment to monitor impact** on population health and wellbeing outcomes.
- **Reflect on our findings throughout the year**
- **Dedicate time for an annual review of progress** in full Board meetings.
- **Report on our progress in the Annual Health and Wellbeing Board report**, sharing accessible updates to our communities and partners.

# References

1. South Gloucestershire Council Health and Wellbeing Board. Joint Health and Wellbeing Strategy 2021-25 [Internet]. 2021 [cited 2024 Dec 6]. Available from: <https://beta.southglos.gov.uk/publications/joint-health-and-wellbeing-strategy/joint-health-and-wellbeing-strategy-2021-25/>
2. South Gloucestershire Council. Community Conversations Strategy [Internet]. 2024 [cited 2024 Dec 6]. Available from: <https://beta.southglos.gov.uk/static/b86605465eea363c0d870f726776fcc5/Community-Conversations-strategy.pdf>
3. National Academies of Sciences E and MD of B and SS and E. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. National Academies Press [Internet]. 2020 Feb 27 [cited 2024 Dec 3]; Available from: <https://www.ncbi.nlm.nih.gov/books/NBK557974/> doi: 10.17226/25663
4. Public Health England. UK Gov. 2015 [cited 2024 Dec 3]. A guide to community-centred approaches for health and wellbeing. Available from: [https://assets.publishing.service.gov.uk/media/5c2f65d3e5274a6599225de9/A\\_guide\\_to\\_community-centred\\_approaches\\_for\\_health\\_and\\_wellbeing\\_full\\_report\\_.pdf](https://assets.publishing.service.gov.uk/media/5c2f65d3e5274a6599225de9/A_guide_to_community-centred_approaches_for_health_and_wellbeing_full_report_.pdf)
5. Dr Claire Fuller. NHSE. 2022 [cited 2024 Dec 3]. Next steps for integrating primary care: Fuller Stocktake report. Available from: <https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf>
6. NHS England. Neighbourhood health guidelines 2025/26 [Internet]. 2025 [cited 2025 Feb 3]. Available from: <https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/#appendix-1>
7. The Department of Health and Social Care. UK Gov. 2024 [cited 2024 Dec 3]. Independent investigation of the NHS in England. Available from: <https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf>
8. NHS England. The NHS Long Term Plan [Internet]. 2019 [cited 2024 Dec 3]. Available from: <https://www.england.nhs.uk/publication/the-nhs-long-term-plan/>
9. UK Legislation. UK Public General Acts. 2022 [cited 2024 Dec 3]. Health and Care Act 2022. Available from: <https://www.legislation.gov.uk/ukpga/2022/31/contents>
10. Department of Health and Social Care. UK Gov. 2021 [cited 2024 Dec 3]. The Best Start for Life - The Early Years Healthy Development Review Report. Available from: <https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical-days>



# References

11. The Health Foundation. The Health Foundation . 2020 [cited 2024 Dec 3]. Using economic development to improve health and reduce health inequalities. Available from: <https://www.health.org.uk/sites/default/files/upload/publications/2020/InclusiveEconomiesReport.pdf>
12. Marmot M. Fair society, healthy lives : the Marmot Review : strategic review of health inequalities in England post-2010. Department for International Development, UK Gov [Internet]. 2010 Jan 1 [cited 2024 Dec 4]; Available from: <https://www.gov.uk/research-for-development-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010>
13. South Gloucestershire Council. South Gloucestershire Council Plan 2024-28 [Internet]. 2024 [cited 2024 Oct 31]. Available from: <https://beta.southglos.gov.uk/our-priorities/>
14. Bristol NS and SGICP. Bristol, North Somerset and South Gloucestershire Integrated Care System Strategy [Internet]. 2023 [cited 2024 Dec 6]. Available from: [https://bnssghealthiertogether.org.uk/wp-content/uploads/2023/06/ICS\\_Strategy\\_V2.8\\_01112024.pdf](https://bnssghealthiertogether.org.uk/wp-content/uploads/2023/06/ICS_Strategy_V2.8_01112024.pdf)
15. Bristol North Somerset and South Gloucestershire Integrated Care Board. Bristol, North Somerset and South Gloucestershire 2024-2029 Joint Forward Plan [Internet]. 2024 [cited 2024 Dec 6]. Available from: <https://bnssghealthiertogether.org.uk/wp-content/uploads/2024/05/BNSSG-2024-2029-Joint-Forward-Plan-full-FINAL-version.pdf>
16. Marmot M et al. The Institute of Health Equity. 2020 [cited 2024 Dec 6]. Health Equity in England: The Marmot Review 10 Years on . Available from: <https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf>
17. South Gloucestershire Council. Children & Young People’s Needs Assessment 2023 [Internet]. 2023 [cited 2025 Jan 30]. Available from: [https://beta.southglos.gov.uk/static/74b2775f0d790e0d2b46d35572e1c5c3/CYPNA\\_2023\\_Long-read.pdf](https://beta.southglos.gov.uk/static/74b2775f0d790e0d2b46d35572e1c5c3/CYPNA_2023_Long-read.pdf)
18. South Gloucestershire Council. Adult Social Care & Ageing Well Needs Assessment Phase 1, May 2024. [Internet]. 2024 [cited 2025 Jan 30]. Available from: <https://beta.southglos.gov.uk/static/e79c759c6b74ad0a48cddc81054c4a2c/Ageing-Well-Needs-Assessment-2024.pdf>
19. South Gloucestershire Council. Tackling Inequalities Plan 2024-28. [Internet]. 2024 [cited 2025 Jan 30]. Available from: <https://beta.southglos.gov.uk/static/5aed2bddea503ee043a106435d6253af/Tackling-inequalities-action-plan-24-28-web.pdf>
20. Raleigh V JDWD. The Kings Fund. 2022 [cited 2024 Dec 4]. Cardiovascular disease in England. Available from: <https://www.kingsfund.org.uk/insight-and-analysis/reports/cardiovascular-disease-england>
21. Park H et al. Relative Contributions of a Set of Health Factors to Selected Health Outcomes. National Library of Medicine [Internet]. 2015 Dec [cited 2024 Dec 4];49(6). Available from: <https://pubmed.ncbi.nlm.nih.gov/26590942/>

## Joint Local Health and Wellbeing Strategy for 2025-29

About this survey During 2024, the Health and Wellbeing Board collaborated with system partners to develop a new South Gloucestershire Joint Local Health and Wellbeing Strategy for 2025-29. They reflected on the strengths and challenges of the previous strategy, the work of the Board, the Joint Strategic Needs Assessment process and local priorities.

This new strategy will be rooted in an understanding of local data and insights set out in our Joint Strategic Needs Assessment and takes an evidence-based approach. We would like to hear your views on the content of the draft strategy, particularly:

- the vision of the strategy,
- the commitments to develop ways of working, and
- the sections setting out how we will deliver the priorities.

Having considered feedback offered during this engagement, we plan to present the final strategy to the Health and Wellbeing Board in May 2025 for agreement. The deadline for responses is 5pm on Friday, 4 April 2025.

### Section 1: Our vision

We have defined two visions for the strategy. One setting out the outcomes we want to achieve for residents and a second vision setting out our ambition for how we will work together.

#### **For South Gloucestershire residents:**

South Gloucestershire is a healthy and inclusive place for current and future generations which supports and enables those who need help the most to improve their health the fastest.

#### **For the South Gloucestershire health and care system and partners:**

The Health and Wellbeing Board, its partners and local communities will work closer together to reduce inequalities and hold ourselves to account on our commitments to create a healthier and more inclusive place for all.

To what extent do you agree with the vision for residents? Well-being Strategy

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

To what extent to you agree with the vision for partner organisations?

- Strongly disagree
- Disagree
- Neutral
- Agree
- Strongly agree

Do you have any comments on either vision?

## Section 2: How we will work together

The strategy sets out five commitments to develop how the Health and Wellbeing Board makes decisions and works with partners over the next four years. In addition to the commitments, there will be up to four annual areas of focus. The commitments will be used as a lens to guide the annual areas of focus, Board discussions and decisions. Any proposal requesting Board approval will need to show how it supports delivery of this strategy.

To what extent do you agree with the five commitments?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Strengthening community involvement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Building a programme of place-based working	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Doing more to reduce inequalities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Shifting upstream with a focus on prevention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Strengthening our use of data and insights in decision-making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Do you think there is anything missing from the commitments which should be included?

For each of the five commitments, we have agreed a set of actions and priorities and we've tried to define how we'll know if we're making a difference.

### Commitment 1: Strengthening community involvement

Do you think we've set out the right ways to achieve this commitment?

Do you think these are the right measures of success?

Is there anything else which you would like to tell us about this commitment?

### Commitment 2: Building a programme of place-based working

Do you think we've set out the right ways to achieve this commitment?

Do you think these are the right measures of success?

Is there anything else which you would like to tell us about this commitment?

Could strengthen how other partners eg housing dept, education sector will work with the locality partnership. If not the risk is that significant determinants of health outside locality partnership control are not as engaged. Noting CYP and housing are 2 of the 4 aims

### Commitment 3: Doing more to reduce inequalities

Do you think we've set out the right ways to achieve this commitment?

Do you think these are the right measures of success?

Is there anything else which you would like to tell us about this commitment?

#### Commitment 4: Shifting upstream with a focus on prevention

Do you think we've set out the right ways to achieve this commitment?

Do you think these are the right measures of success?

Is there anything else which you would like to tell us about this commitment?

#### Commitment 5: Strengthening our use of data and insights in decision-making

Do you think we've set out the right ways to achieve this commitment?

Yes - South Gloucestershire has strengths in presenting data and making it accessible to partners. To make more effective use of this capability, the Board could set clear metrics for priorities.



Yes

Is there anything else which you would like to tell us about this commitment?

## How we will deliver this strategy

We will publish an action plan for each year of the strategy's life and use a new accountability process to monitor progress.

To what extent do you agree with our delivery principles?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Each year, we will identify up to four Health and Wellbeing Board Annual Focus Areas for the year ahead.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
We will monitor progress of the strategy throughout its lifetime.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Our new accountability process will include opportunities for ongoing reflection and iteration within the full meeting cycle of the Board.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
We recognise that we may need to adapt this strategy and our actions in response to what we learn	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
We will publish a Health and Wellbeing Board Annual Report which will summarise strategy progress, celebrate successes and set out plans for the year ahead.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Do you think there is anything missing from the delivery principles which should be included?

No

## Annual focus areas

Do you agree with the principles for the selection of annual focus areas?

The principle that they should be local, system or national priorities seems to lack meaning. There is a risk that the priorities are not aligned with system/national priorities and then are quite difficult to make progress on.

	Yes	No
Children and young people	<input type="radio"/>	<input type="radio"/>
Healthy weight	<input type="radio"/>	<input type="radio"/>
Housing and health	<input type="radio"/>	<input type="radio"/>
Place-based working and Neighbourhood Health	<input type="radio"/>	<input type="radio"/>

If you disagree with any of the focus areas, it would be helpful to understand why.

Do you have any other suggestions for annual focus areas?

## Working together in a new way

Do you think these new ways of working will support us in achieving our priorities?

Do we have the right measures in place to test whether we are making a difference?

Do you have any other comments about the content of the Joint Local Health and Wellbeing Strategy?

The draft strategy is a helpful document and we look forward to working as a partnership to deliver on the commitments and vision set out.

## About You

This section is really important. It's vital that we understand the experiences of a wide range of respondents in order to ensure that everyone is treated equally. By understanding more about what people from diverse backgrounds tell us, we can ensure we act appropriately to meet needs. All questions are optional and any responses to these questions will remain confidential. Individuals will not be identified and personal details will not be published.

What is your age? 14. South Gloucestershire Joint Health and Well-being Strategy

- |                                |                                |   |
|--------------------------------|--------------------------------|---|
| <input type="radio"/> Under 18 | <input type="radio"/> 40 to 49 | <input type="radio"/> 70 to 79          |
| <input type="radio"/> 19 to 29 | <input type="radio"/> 50 to 59 | <input type="radio"/> 80 or over        |
| <input type="radio"/> 30 to 39 | <input type="radio"/> 60 to 69 | <input type="radio"/> Prefer not to say |

Are you?

- Female
- Male
- Other
- Prefer not to say

Please tell us your sexual orientation

- Straight or Heterosexual
- Gay or Lesbian
- Bisexual
- All other sexual orientations
- Prefer not to say

Do you consider yourself to be disabled? **(Please tick all that apply)**

- No
- Prefer not to say
- Yes - Physical impairment, such as difficulty using arms or mobility issues which may mean using a wheelchair or crutches
- Yes - Sensory impairment, such as being blind/having a serious visual impairment or being deaf/have a hearing impairment
- Yes - Mental health condition, such as depression, anxiety or schizophrenia
- Yes - Learning disability/difficulty (such as Down's Syndrome, dyslexia, dyspraxia) or cognitive impairment (such as autism spectrum condition)
- Yes - Long standing illness or health condition, such as cancer, HIV, diabetes, chronic heart disease or epilepsy
- Yes - Other (please state)

What is your ethnic group?

- White
- Mixed or Multiple ethnic groups
- Asian or Asian British
- Black, Black British, Caribbean or African
- Other ethnic group
- Prefer not to say

Thank you for telling us your views, please click on the **SUBMIT** button below to send us your response. It is a grey box with a tick if you're using a mobile or tablet.

Any personal information that you have supplied will be held by South Gloucestershire Council in accordance with the Data Protection Act 2018 and UK General Data Protection Regulations (UKGDPR) 2021. This information will only be used as part of this exercise and personal information will not be published or passed onto any other organisation. Your personal information collected as part of this survey will be kept for two years to help us improve services before being securely destroyed. Our privacy notice, which explains how we will process your personal information, how long we will retain it and your rights as a data subject, is available at [www.southglos.gov.uk/privacy](http://www.southglos.gov.uk/privacy)

<b>Report To:</b>	Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Operational Plan Final Submission 2025/26		
<b>Report Authors:</b>	<p>Simon Davies, Director of Operational Finance</p> <p>Henry Yip, Head of Business Planning</p> <p>Nicholas Smith, Interim Chief Operating Officer</p> <p>Caroline Bird, Director of Reset and Recovery</p> <p>Lisa Whitlow, Director of Performance</p> <p>Ben Pope, Associate Director for Workforce Planning, People Systems and Data</p>		
<b>Report Sponsor:</b>	Elizabeth Poskitt, Chief Finance Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
	X		X
	<p>This paper is updating the Trust Board on the work undertaken to finalise Business and Operational Planning for 2025/26 and represents the submission to NHS England on 27 March 2025.</p> <p>The Trust Board is asked to:</p> <ul style="list-style-type: none"> <li>• Note the Final position for NBT Business and Operational Planning for 2025/26. The plan will deliver a breakeven financial position and is compliant across performance metrics.</li> <li>• Note that the Joint Chief Executive and Hospital Managing Director have approved the plan for submission to NHS England, in line with delegation from Trust Board, due to the timing of submission on the same day as the Board meeting.</li> <li>• Note the amendment between the Headline and Final submission for key metrics to be submitted 27 March 2025.</li> <li>• Note the approach to capital funding and allocation, including the over-programming.</li> <li>• Note the risks included in the plan, and the approach to mitigating these.</li> <li>• <b>Approve</b> the final budget for 2025/26, in advance of the start of the financial year.</li> </ul>		



### Key Points to Note *(Including any previous decisions taken)*

The Trust Board is asked to approve the final budget for 2025/26, in advance of the start of the financial year.

The January Trust Board delegated authority to the Joint Chief Executive and Hospital Managing Director to sign off the Final plan in advance of March Trust Board following approval of the Headline submission at Finance, Digital and Performance Committee (FDPC) in February. The March FDPC scrutinised the key elements of the plan.

This is in line with the nationally mandated governance required to provide Board assurance of operational plans for 2025/26. Trust Board is asked to note the work undertaken since the Headline submission to deliver a Final Operational Plan for the Trust's and BNSSG ICB System's Final submission on 27 March 2025 to NHS England.

This paper outlines the changes to the Headline submission which have delivered a final plan which is financially breakeven and delivers compliant performance levels. The key updates for the final plan are outlined in the below table of changes:

Date	Position
Headline submission 27 February 2025	<p>Key areas:</p> <ul style="list-style-type: none"> <li>• Non-Compliant against delivering a minimum 5% point improvement on patients waiting no longer than 18 weeks for treatment. Target 72% but reporting 67% achievement.</li> <li>• Dependent on sufficient ERF funding: Improve patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026.</li> <li>• All other key performance objectives were targeted to be delivered.</li> <li>• BNSSG financial position reporting a £44.8m deficit, with NBTs contribution to the position at £16.1m.</li> </ul>
Final submission 27 March 2025	<p>Key areas:</p> <ul style="list-style-type: none"> <li>• All key performance objectives are targeted to be delivered. (see table 1)</li> <li>• Workforce – bank and agency reductions in line with guidance are included, as well as changes to substantive headcount, however overall, this is above establishment.</li> <li>• The financial plan is now reflecting a breakeven position. This includes actions to close the £16.1m gap from Headline to Final.</li> </ul> <p>Outstanding next steps at Headline submission now resolved at Final plan:</p> <ul style="list-style-type: none"> <li>• Bristol Surgical Centre – included in plan.</li> <li>• ERF planning – £10m of ERF funding prioritised.</li> <li>• Inflation, depreciation and technical accounting impacts – modelled in, including PFI accounting treatment offset by income.</li> </ul>

	<ul style="list-style-type: none"> <li>• BNSSG income schedules – included in plan.</li> <li>• Specialised commissioning plans – included in plan.</li> <li>• Cash – Cashflow projections indicate sufficient availability; however, cash balances are expected to decline significantly over the year.</li> <li>• Headcount modelling – included in plan. Additional in year controls will now be put in place.</li> <li>• Temporary staffing savings – included in plan.</li> <li>• Savings target – Central actions will be taken to deliver the further 1% / £7.8m to achieve overall total savings of £40.6m.</li> <li>• UEC and NC2R – to be delivered contingent on NCTR being reduced to 15%.</li> <li>• A&amp;E – attendance growth agreed at 4%; c309 attendances per day.</li> <li>• Cancer Delivery – already demonstrated compliance.</li> </ul>
<b>Strategic Alignment Group Model Alignment</b>	
<p>The Business Planning function enables the Trust to demonstrate plans that aims to deliver against the Trust’s strategic priority.</p>	
<p>NBT and UHBW work alongside each other to prepare aligned Business and Operational Plans, where appropriate.</p>	
<b>Risks and Opportunities</b>	
<p>Risks are outlined in the paper.</p>	
<b>History of the paper (details of where paper has <u>previously</u> been received)</b>	
<p>The approach to planning has been reported via various Business Plan update papers to Finance, Digital &amp; Performance Committee and Trust Board via upward reporting, as well as through Executive Team Meetings and Strategic Leadership Groups.</p>	
<b>Appendices:</b>	<p>Appendix 1: Board Assurance framework</p> <p>Appendix 2: Health Inequalities focus</p> <p>Appendix 3: Productivity response</p> <p>Appendix 4: Workforce Final submission and NBT’s Contribution towards national guidance.</p> <p>Appendix 5: Final Budget 2025/26</p> <p>Appendix 6: 2024/25 Forecast Outturn to Underlying Position</p> <p>Appendix 7: Financial Underlying Position to 2025/26 Final Plan</p> <p>Appendix 8: 2023/24 Underlying to 2024/25 Underlying Position</p>

## 1. Purpose

This paper is setting out to the Trust Board the Final Business and Operational Planning for 2025/26. This is the position approved by Joint Chief Executive and the Hospital Managing Director in relation to the Final submission due on 27 March 2025. The position in this paper represents the resolution of issues that were outstanding at Headline submission and now reporting a compliant performance and breakeven financial plan. Any further updates to the contents as described in this paper can be made ahead of Final submission, with delegation of the Final submission authorised to the Joint Chief Executive and the Hospital Managing Director to accept any changes required. The 27 March 2025 submission to NHS England covers activity, performance, workforce and finance key metrics. Table 1 compares the Headline submission against the Final submission.

Key Performance Metric	Headline submission	Final submission
Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026	Compliant	Compliant: Contingent on NCTR to reduce to 15%
A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	Relationship between 4 and 12 hrs is maintained	Compliant: Relationship between 4 and 12 hrs is maintained
Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	Compliant	Compliant
Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	67% (non compliant to deliver a 5% improvement)	Compliant (72%)
Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement*	Compliant dependant on sufficient ERF funding	Compliant (78%)
Improve performance against the headline 62-day cancer standard to 75% by March 2026	Compliant	Compliant

Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	Compliant	Compliant
Deliver a balanced net system financial position for 2025/26	Non-compliant	Compliant
Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Non-compliant	Compliant
Close the activity/ WTE gap against pre-Covid levels (adjusted for case mix)		Working towards meeting this success criteria once defined.
Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'	Compliant	Compliant
Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	Compliant	Compliant

Table 1

The approach undertaken aligns with the development of the system plan with the Bristol, North Somerset & South Gloucestershire Integrated Care System (BNSSG ICB), which the North Bristol NHS Trust plan is incorporated into.

## 2. Background

The work on Business Planning has been reported via various updates to Finance, Digital & Performance Committee and Trust Board, as well as through Executive Team Meetings and Senior Leadership Groups since the launch of 2025/26 planning in September 2024.

National planning guidance was released 30 January 2025. The national message was clearly stated - that NHS organisations are expected to live within their means and that will require maximising productivity. The focus is to maximise resources available for clinical services, given the financial constraints, which may result in difficult decisions being required, including reducing or stopping spending on some services and functions and to achieve unprecedented productivity growth in others.

For the 2025/26 Business Planning round, two submissions are required by NHS England. The first is a Headline submission on 27 February 2025 and then a Final submission on 27 March 2025. Both will have been submitted by the time Trust Board reviews this paper.

Finance, Performance and Workforce Submission templates, alongside a Final submission checklist which includes a narrative covering productivity and efficiency, Elective and UEC plans for 2025/26, at both a provider and ICS level will have been shared with the ICS on 24 March and these submissions form the basis of this paper.

A Board Assurance Framework (Appendix 1) is requested for Final plan submission. NHS England expect Boards to be involved throughout the development of plans, and ICBs and providers must work together to ensure that the submission reflects the collective intentions of the system.

Whilst the NHS England submission requires key performance metrics, it should be noted that work on wider Operational Planning continues, which includes the refresh of Patient First priorities and work on Health Inequalities. Current assumptions towards delivery of Health Inequalities requirements have been outlined in Appendix 2.

The expectation from NHS England is that providers and systems will breakeven, in addition to achieving the performance standards. The Trust's Final plan is compliant following resolution to issues outlined in the Headline submission.

The sections below set out the activity, performance, workforce and finance elements of the operating plan. These have been aligned through the divisional review process and through the planning working group maintaining links and triangulation between each area.

Planning sessions have been held with each division and corporate directorates in January, February and March. This ensures that planning from a divisional level continues to support the setting of deliverable plans.

### **3. Operating Plan 2025/26**

#### **3.1. Activity plans**

Activity plans have been developed on a bottom-up basis at divisional level based on deliverability.

The Headline submission did not include the impact of the Bristol Surgical Centre but that has now been incorporated into the final plan. The plan is based on the 'Displacement' clinical model for the Bristol Surgical Centre which expects the centre to open in mid-August for four theatres of Orthopaedic activity and to start delivering productivity gains from September 2025. The plan also reflects NBT additionality in Brunel (two theatres) and UHBW transfer of activity to NBT (two theatres) and UHBW additionality from mid-August to September 2025.

Prioritisation of Elective Recovery Funding (ERF) has been concluded, and the prioritised investments are reflected in the activity plans.

The Trust has used the GooRoo modelling tool to a greater extent as the basis for demand and capacity modelling for 2025/26. Diagnostic modalities have continued to use IMAS. In addition, the Trust's Senior Operational Modelling Lead has developed models to aid with producing plans to deliver new national RTT wait times requirements. UEC growth is aligned with ICB modelling.

##### **3.1.1. The key assumptions on activity are:**

- 'Yes if' plan – continue to deliver non-recurrent ERF mitigations from 2024/25 plus all new investment requests (£10m of ERF has been switched on),



- UEC delivery contingent on NCTR being 15%, as plan assumes all Trust actions have been undertaken to meet performance at this level of NCTR,
- A&E attendance growth 4% on top of Month 9 Forecast Outturn (5.6% Majors; 1.3% Minors); c.309 attendances per day,
- Non-Elective (NEL) admission growth 3%; split of 54% 0-day Length of Stay (LoS) / 46% 1+day-LoS,
- Core capacity of 878 beds with escalation to mitigate >100% occupancy,
- Target bed occupancy 93% (NEL 92%; EL 95%),
- Minimum 2 ring-fenced elective wards in the Brunel Building and Bristol Surgical Centre are ring fenced,
- Cancer performance metrics are for delivery in the final quarter, the plan assumes delivery in line with standards by this point. It is dependent upon SWAG funding being available at current levels.

### **3.1.2. Key Deliverables**

- ED 4-hour: 78% by year end (March 2026) including 7.9% footprint uplift – improvement will be subject to robust system plans including NC2R reduction down to 15% by year end,
- RTT: Deliver 72% of patients waiting no more than 18-weeks by year end; deliver 78% 1st OPA within 18-weeks; continue to deliver no more than 1% of the wait list waiting >52-weeks,
- Diagnostics: continue to deliver 1% national standard with 0 x 13-week breaches,
- Cancer: 62-day combined delivery of 75% by year end; FDS 80% by year end.

### **3.1.3. Plan position NBT**

The activity plan set out using the contract income currency within SLAM (the contract income monitoring system used by the Trust) is in Table 2 below.

	Activity			Income (£m)		
POD	2019/20	2025/26	% of 2019/20	2019/20	2025/26	% of 2019/20
Elective inpatients	14,148	15,714	111.1%	66.1	77.7	117.5%
Day Case	54,266	70,041	129.1%	51.4	70.5	137.2%
<b>Total Elective</b>	<b>68,414</b>	<b>85,755</b>	<b>125.3%</b>	<b>117.5</b>	<b>148.2</b>	<b>126.1%</b>
Outpatient First	113,085	137,125	121.3%	26.2	30.7	117.2%
Outpatient Procedure	46,154	63,855	138.4%	10.0	14.9	149.0%
<b>Total ERF Outpatients</b>	<b>159,238</b>	<b>200,980</b>	<b>126.2%</b>	<b>36.2</b>	<b>45.6</b>	<b>126.0%</b>
<b>Total ERF</b>	<b>227,652</b>	<b>286,735</b>	<b>126.0%</b>	<b>153.7</b>	<b>193.8</b>	<b>126.1%</b>
Outpatient Follow Up	289,234	283,008	97.8%	44.6	45	100.9%
NEL	98,689	112,640	114.1%	20.0	24.5	122.5%
A&E	67,387	85,151	126.4%	185.5	206.5	111.3%

Table 2

The activity baseline which the Trust will be measured against is SUS (national repository for healthcare data), which is different to SLAM but not how the Trust routinely reports income. Our assessment of the impact of the conversion from SLAM to SUS is in the below Table 3. Within the Trust's assessment based on SUS, it should be noted that CDC activity is included in the Day Case activity, as is other Endoscopy activity. This is not included in the Elective Recovery calculation in table 2 above.

POD	% of 2019/20 SUS
ED Attendances	114.1%
NEL Zero LoS	146.7%
NEL 1+day LoS	119.6%
OP First Attendance	123.0%
OP Follow UP	97.8%
OPPROC	138.4%
EL Day Case	129.1%
EL Inpatient	116.7%

Table 3

## 3.2. Performance

### 3.2.1. Elective Care

Whilst previous planning rounds, following the pandemic, have focussed on backlog clearance and reduction of the longest-waiting patients, the guidance for 2025/26 and in the Elective Reform publication, renews focus on overall compliance with the 18-week RTT standard.

The Trust has already delivered the minimum national requirements for both wait time for first activity and proportion of patients waiting over 18-weeks. Therefore, the Trust's plans are focussed on delivery of the 5% stretch target for both metrics.

The Trust will be expected to deliver a minimum of 72% of patients waiting less than 18-weeks for their treatment and a minimum of 78% of patients waiting less than 18-weeks for their first activity.

The Trust has developed plans that demonstrate the additionality in activity and improved productivity required to deliver these improvements. This is in addition to the opening of the Bristol Surgical Centre in 2025.

The Trust has also already delivered no more than 1% of the total wait list waiting over 52-weeks; plans for 2025/26 will ensure that delivery of this standard is sustained, and key focus will be on ensuring progress is continued at pace to enable delivery of the 18-week constitutional standard.

### 3.2.2. Cancer

Cancer targets for delivery by March 2026 are:

- *Faster Diagnosis – 80% of patients will be given a diagnosis within 28 days.*
- *75% will be treated within 62 days for cancer.*

The implementation and continuation of new pathways will support sustained improvements in faster diagnosis. For Skin, 11 PCNs are now delivering teledermatology referrals with further expansion planned in 2025. In Gynaecology, the new direct to test pathway launched in January 2025 will reduce demand on the cancer pathway and support earlier diagnosis.

The introduction of the Bristol Surgical Centre will provide some additional capacity and efficiency to deliver surgical interventions.

NBT will continue to use external funding to support delivery plans. The South West Cancer Alliance (SWAG) have not yet provided the non-recurrent funding profile for 2025/26. NBT will focus this funding on extending initiatives delivered in 2024/25 including pathology additionality, waiting list and other elective additionality. It is assumed that funding will be less than that available in 2024/25, however additional in year funding will continue to support all at risk phases of the pathway to deliver performance improvements before year end.

### 3.2.3. Diagnostics

- *National wait time standard of no more than 1% of patients waiting >6-weeks for their diagnostic test.*

Whilst not explicitly covered in the operational planning guidance for 2025/26, it is understood that the expectation is for trusts to be back to compliance with the 1% national standard. The Trust plans to continue to deliver this requirement and maintain clearance of over 13 weeks.

- *Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.*

The Trust plans to deliver sufficient activity to deliver elective, cancer and diagnostic waiting times ambitions. The Trust's plan includes CDC activity and non-recurrent mitigations including insourcing/outsourcing of activity, including waiting list initiatives and Independent Sector capacity. The use of these mitigations varies across modalities with some modalities now delivering within sustainable core capacity e.g. DEXA scans and Respiratory Physiology – Sleep Studies.

### **3.2.4. Productivity**

NHS organisations will need to reduce their cost base by at least 1% and achieve 4% improvement in productivity, in order to deal with demand growth. This is a step change across all services. The Trust must demonstrate that all productivity and efficiency opportunities have been exhausted before considering where it is necessary to reduce or stop services, taking account of each organisation's own legal duties.

NHSE have published productivity and efficiency packs at a Trust level to support the identification of opportunities. Measures have been identified across nine areas including clinical and operational productivity and efficiency (see Appendix 3).

The Productivity Packs show NBT as an outlier, this is due to the use of the 2023/24 National Cost Collection as the basis for the calculation. There was an accounting change in 2023/24 relating to the PFI which was excluded from the Trust's control total to achieve breakeven. However, the impact appears to have been included in the metrics received, thus driving the position. The Trust is working with both regional and national colleagues to find a route to replicate the calculation with the PFI impact removed.

The Trust has reviewed the outputs of national data and discussed the approach through Finance Sustainability Board. Key areas of focus for the Trust will be temporary staffing, commercial procurement, and elective and outpatients. This will include driving improvements in operational and clinical productivity, with a specific focus on outpatients and theatre efficiency.

Progress has been made in recovering activity in the last year and improving some key productivity and efficiency metrics. Productivity, therefore, remains a critical component of the Trust's recovery and sustainability plans.

The Trust's approach continues to be data driven, using comparative and benchmarking information, including Getting it Right First Time (GIRFT), to highlight areas for improvement.

There remain some challenges for NBT in improving its productivity and efficiency, including our disproportionately high no criteria to reside position; workforce constraints; lack of anaesthetic rooms in Brunel Theatres and

outsourcing of a significant amount of High-Volume Low Complexity (HVLC) cases to the independent sector. Despite these constraints, however, we have identified opportunities for improvement. These include:

- Through NBT's Outpatient Board, the Trust continues to progress projects supporting both the recovery and productivity and efficiency agenda. Continuing projects are focused on maximising outpatient room utilisation and reducing Did Not Attends (DNAs), with digital transformation as an enabler, to ensure NBT is making best use of its limited resources to provide the best patient care. An additional focus for 2025/26 will be on optimising outpatient clinic templates, with an initial focus on five specialties in quarter one before a rollout to other areas.
- Through the Theatre Efficiency Group, delivery of a comprehensive improvement plan focusing on improving Capped Theatre Utilisation. This work has improved the capped theatre time from 75% to 79% in this year. This has led to an improvement in the number of cases being delivered per day. A key area of efficiency will be when the Bristol Surgical Centre is functioning, this has been designed to be able to maximise GIRFT guidance on high volume lists. The organisation has a maturing Prehabilitation service which optimises patients prior to surgery and there are plans to increase the operating day in Gynaecology to maximise the use of the current estate.

### **3.2.5. Urgent Emergency Care (UEC)**

As in 2024/25, improvements in performance in UEC metrics are dependent on:

- management of front door demand,
- streamlining and redirection,
- reducing time in department,
- improving timeliness of ambulance handovers,
- improving flow into and out of the bed base, and
- crucially, reducing the number of beds occupied by NC2R patients.

This is set in the context of continuing growth in ED attendances, particularly Majors, and remaining being an outlier regionally and nationally on NC2R.

The 2025/26 internal programme of work will continue to focus on two areas – the front door and flow and discharge. Governance and oversight of the implementation of agreed schemes will continue through the established UEC Transformation Programme Board, chaired by the Chief Operating Officer with further Executive Sponsorship from the Chief Medical Officer and Chief Nursing Officer.

Given the system wide nature of Urgent and Emergency Care, NBT representatives will also continue to pro-actively participate in system level governance structures, as required, and work with partners to support the implementation of the UEC and Home First Plan.



### 3.3. Workforce

National planning guidance for workforce sets out clear expectations to reduce workforce cost and whole time equivalent (wte) and for workforce to contribute towards improving productivity. Guidance sets out expectations to ensure:

- Optimisation of the substantive workforce, delivering reduction in spend (and use) of bank (10% reduction) and agency (30% reduction) and review support function establishment to return expenditure to April 2022 levels.
- Overall workforce does not exceed budgeted establishment from a WTE and pay perspective with delivery enabled by implementing workforce controls and improving productivity, closing the WTE and activity productivity gap.

Delivery is underpinned through the utilisation of available tools, such as eRostering and eJobPlanning, and in continuing progressing our strategic commitments to our People through delivery of the People Promise, the six national high impact Equality, Diversity and Inclusion actions, our Health, Wellbeing and Resilience plan and through targeted resourcing activity.

#### 3.3.1. Assumptions and Modelling Approach

##### 3.3.1.1. Supply

Our supply forecast is based on the underlying assumption that we can achieve, where required, supply rates from the last 12 months for clinical roles, with known exceptions applied, e.g., specific recruitment volumes for clinical professions; undergraduate pipelines, apprenticeships, targeted domestic recruitment, recruitment plans for hard to fill posts, resident doctor expansion and areas where deterioration in available supply is anticipated. Targeted analysis of supply for clinical professions has been worked up through the relevant People Governance routes, including Nursing Workforce Committee and AHP Workforce.

##### 3.3.1.2. Retention

Our plan assumes current levels of turnover continue. Our plans continue to focus on improving our turnover position in targeted areas, particularly frontline clinical teams. However, given the considerable work over the past 12 months to improve staff retention, close our vacancy gaps and enhance staff experience. There is a risk with the focus on headcount reduction and continued reduction in temporary staffing that we could start to see these positive retention trends impacted.

##### 3.3.1.3. Substantive Workforce Growth

Our plan assumes growth in our substantive workforce where existing budgeted clinical vacancies are being filled or where there is an agreed and funded workforce expansion. The impact of the Bristol Surgical Centre on workforce demand and supply is the most significant area of workforce growth, currently 273 wte for NBT. In addition, re-investment of nursing temporary staffing budget into substantive staffing has been agreed to reflect safe staffing and headroom need, this aligns with planning guidance on productivity aimed at reducing the use of premium cost staff through establishment reviews. The final area of workforce growth is NHS England's national

expansion of Resident Doctors with the Trust receiving 12 additional doctors from August 2026.

#### **3.3.1.4. Workforce Cost Reduction**

Recognising the need to reduce our workforce costs to meet national guidance and contribute to Trust savings requirements, our assumption is that we will deliver workforce reduction. To deliver the required savings our targeted reduction is 211 wte. This will manifest as a budget reduction of 211 wte and a substantive staff reduction of 180 wte (assuming that some of the 211 wte will be currently vacant posts). The mechanisms to underpin the delivery are being rapidly worked up and will be presented to the Executive Management Team for sign off. This includes a proposal for enhanced governance and oversight, strengthening the role of the Resourcing and Temporary Staffing Oversight Group established July 2024, chaired by the Chief People Officer. The group will play a pivotal role in terms of monitoring the impact of our workforce plans, particularly on delivery of the required cost savings and the impact of controls.

#### **3.3.1.5. Temporary Staffing**

NHS England planning priorities for 2025/26 require a reduction in bank and agency expenditure of 10% and 30% respectively of our overall spend on bank and agency in 2024/25. The 2025/26 plan assumes that the improvements will be delivered over the course of the year in reduced temporary staffing use. Delivery will be through additional controls, conversion of agency to bank and substantive, establishment reviews, work on rota design for Resident Doctors. In addition, we will identify opportunities through cost improvements, reviewing rates and opportunities for direct engagement of agency staff.

#### **3.3.1.6. Workforce Productivity**

Encompasses aspects directly relating to workforce use and cost and the specific aspects of the guidance are outlined in the productivity section above and throughout section 3.3.1.

### **3.3.2. Workforce Submission**

The table in Appendix 4 shows the final submission alignment with national planning guidance and key wte changes in our anticipated workforce position for 2025/26.

### **3.3.3. Summary Key Performance Indicators (KPIs for Workforce)**

NHS England focus on two workforce KPIs, Turnover and Sickness. Additional success measures focussing on agency and bank reduction and reduced spend on support functions have been described in the NHS England's guidance and described above in section 3.3.1 will be monitored in 2025/26.

There are additional success criteria in the planning guidance relating to the closure of the wte and activity productivity gap and the delivery of the NHS People Promise and six high impact Equality, Diversity and Inclusion actions. We will work to develop any additional measures, either required by NHS England or determined as required internally, to support monitoring of delivery against these criteria in 2025/26.

Our turnover target for 2024/25 (11.9%) has been achieved and is 11.6% in February 2025. Given the anticipated pressure on staff due to the additional workforce controls that will be in place next year, we assume no further improvement in turnover overall will be achieved in 2025/26. We continue to deliver our long-term retention plan aims and interventions with a focus on 2025/26 on culture, 'living our values', flexible working and career development and coaching to build long term careers in the Trust and will take a targeted approach to improvement focussing primarily on clinical and business critical roles.

Our sickness absence rate is currently above our 2024/25 targets (4.4%) at 4.6% in February 2025. Our draft target for sickness for 2025/26 remains 4.4%. Improvement has been delivered in 2024/25, but our rolling 12-month sickness position has 'plateaued' at 4.6% over the last six months. Retaining a target of 4.4% aligns with ongoing focus on improving staff Health and Wellbeing whilst recognising that further stretching targets may not be achievable due to ongoing and increasing pressures on the workforce driven by cost reduction requirements.

The risk to deliver these targets has been highlighted to the ICS through the planning process as part of a wider risk to staff retention, engagement and health and wellbeing.

Overall impact of anticipated pressures - there has been considerable work over the past 12 months to improve staff retention, close our vacancy gaps and enhance staff experience. There is a risk with the focus on headcount reduction and continued reductions in temporary staffing that we could start to see these positive trends impacted. We have mitigations to help address this, but with additional pressures due to patient acuity, increased demand on our services, and no criteria to reside, there is a risk that these trends could be negatively impacted.

There is a risk that headcount reduction and efficiencies across the acute sector result in periods of significant organisational change across our workforce and the potential need to make difficult decisions regarding recruitment into vacancies and the potential for redundancies. We have robust organisational change policies and procedures to support this, and every effort will be made to avoid redundancies, and we are already working closely with partner organisations and prioritising redeployment across our services wherever possible. However, there is a need to ensure that appropriate approval mechanisms regionally/nationally are in place to support with this level of organisational change, and to ensure that we are supported to manage this in the most efficient and cost-effective way, e.g., consultation closure and in year savings delivery may be at risk due to current regional control on redundancy.

### 3.4. Finance

The Final plan to be submitted by BNSSG ICS is a breakeven position. The NBT position is also showing a breakeven position.

Within the NBT position is:

- £8.1m of provider deficit support income from the system (and per the Medium-Term Financial Plan).
- £7.7m of non-recurrent mitigations or income
- £16.7m of cost pressures recurrently funded
- Savings plan to deliver £40.6m in 2025/26 equating to 5% of turnover as agreed with ICB, made up of:
  - £36.4m of recurrent savings
  - £4.2m of non-recurrent savings

The Elective Recovery Funding recurrently added to baselines in 2023/24, in addition to further funding confirmed for 2025/26, is included within the 2025/26 plan. The Trust has worked with operational teams to prioritise this funding to ensure maximum delivery of targets.

The detailed Budget is in Appendix 5.

A waterfall to show the movement from the Underlying position to the final 2025/26 plan is shown in Appendix 6.

#### 3.4.1. System Underlying position

Through the 2025/26 planning process each of the organisations within BNSSG has reviewed its underlying position.

The deterioration which NBT has seen due to the non-delivery of savings is reflected in UHBW, who have also not delivered savings recurrently in line with plans set out at the start of 2024/25.

Overall, the combination of non-delivery of provider and system savings, alongside other pressures seen in year, have resulted in the system deteriorating from a planned £68.3m underlying deficit to a £134.7m forecast underlying deficit.

This deficit will need to be recovered, and this aligns with the Trust's own plans to recover its element of the underlying deficit, initially through a combination of non-recurrent and recurrent savings in 2025/26, with fully recurrent initiatives planned in future years.

#### 3.4.2. NBT Underlying position

The NBT underlying position, calculated in December 2024, has deteriorated in year.

The key drivers of this have been:

- Non-delivery of full savings requirement of £28.7m in 2024/25.
- Short fall in 2024/25 pay award funding based on budgeted establishment of £2.5m.

- Non-pay inflation greater than the national Cost Uplift Factor £3.0m.
- Further pressures driven by increased activity on block contracts £6.5m.

Appendix 7 shows the route from the 2024/25 breakeven forecast outturn to the underlying position. Appendix 8 shows the movement from the 2023/24 to 2024/25 underlying positions.

### **3.4.3. Inflation**

Inflation has been one of the most significant drivers in the past two financial years of the underlying position movement and this has only been partially funded nationally.

It should be noted that the 2025/26 pay inflation calculation has been made prior to any announcements on pay settlements and is in line with national planning assumptions. For Final planning, it is assumed that this will be fully funded and there is no financial pressure from the 2025/26 pay award.

The impact of the 2024/25 pay award has not been fully funded nationally. The pressure arises from the funding received for the pay award being calculated on staff in post on 31 March and not funded establishment. However, the ICB has allocated funding for this £2.5m pressure and is included in the Final Plan to offset the cost pressure.

### **3.4.4. Cost Pressures**

A review of cost pressures has been undertaken and the updated Underlying Position reflects these, with funding made available within the final assessment.

This funding will cover the specifics driving the Underlying Position, in addition to any changes in budgets due to business cases and income sources which have changed in year.

### **3.4.5. Elective Recovery Funding**

Elective Recovery Funding (ERF) will continue in 2025/26 however the funding arrangements are now capped. Based on published guidance no additional funding will be available for elective activity beyond that included in the commissioner allocations.

Core and additional ERF has been separately identified in ICB allocations. Distribution of additional ERF funding is based on the forecast outturn for Month 8 2024/25 with adjustments for the impact of Bristol Surgical Centre, scaled back for performance over target set nationally.

Currently only the allocation for BNSSG and Specialised Commissioning has been made available and the Trust, with Associates yet to be confirmed. For BNSSG the allocation of £272.8m represents 113% of the 2019/20 baseline.

ERF for Bristol Surgical Centre (BSC) of £12m is separately identified as part of targeted investment funding (TIF) and £10m of funding has been prioritised to support the delivery of performance standards in RTT and Cancer.

### 3.4.6. PFI PDC Dividend Risk

The PDC Dividend is a charge by NHS England to cover the cost of NHS funds tied in assets (cost of capital). Normally, PFIs, as privately funded assets, do not incur this charge since they already bear private investment costs, including interest.

In 2024/25, the National Finance team introduced adjustments to estimate PDC charges if PFIs were publicly funded, aiming for fair comparisons. However, the NBT finance team argues this method is flawed as it overlooks existing private charges mentioned above. This change was only introduced late in the financial year.

For NBT this increase in PDC charge would be c£5m per annum.

NBT is collaborating with central NHSE finance teams to revise these calculations however the guidance currently received is to include this cost in the Trust's 2025/26 plan. As this is a cost pressure originating from an accounting change for which NBT has no control over NBT have also included additional funding to mitigate this cost. There is a risk that this funding will not be received and the PDC charges as stated above would still stand.

### 3.4.7. Savings

#### 3.4.7.1. Savings delivered prior to 2025/26

The table below shows the level of savings which have delivered historically by the Trust.

Financial Year	Total CIP Delivered (£'m)	Recurrent (£'m)	Non-recurrent (£'m)	Full-Year Effect (£'m)	FYE % of Income
2015/16	27.3	26.3	1.0	29.2	5.0%
2016/17	26.1	25.0	1.1	24.4	5.0%
2017/18	36.8	29.4	7.4	32.8	6.0%
2018/19	26.3	15.3	11.0	17.5	3.0%
2019/20	22.1	15.4	6.7	18.6	3.0%
2020/21	2.5	2.5	0.0	2.5	0.4%
2021/22	3.5	3.5	0.0	3.5	0.5%
2022/23	6.5	6.5	0.0	6.5	0.8%
2023/24	18.2	18.2	0.0	18.2	2.3%
2024/25	22.1*	22.1	0.0	22.1	2.8%
2025/26	40.6.	36.4	4.2	40.6	5.0%

Table 4

\*This is currently a forecasted Year-End position.

This demonstrates that whilst the level of savings delivered in recent years has been less than 3%, pre-Covid the Trust was delivering over 3% consistently. However as shown above this included non-recurrent savings no longer reported as CIP by the Trust, although an element of non-recurrent will be used to support 2025 / 26 delivery.



### **3.4.7.2. National and local requirements on savings delivery**

The national requirement is for 2.0% of efficiency to be delivered by the Trust as part of the core efficiency. This is an increase from prior years where the national efficiency target was set at 1.1% and the Medium-Term Financial Plan (MTFP) was based on an assumption of a 1.1% national efficiency target.

### **3.4.7.3. Savings Approach for 2025/26**

The Trust has developed savings plans to deliver £40.6m in 2025/26 equating to 5% of turnover which includes the increased national efficiency target. This is in line with the percentage that UHBW are expecting to deliver. Divisions and Directorates will continue to target 4% savings (£32.8m). The approach taken has been to ask each area to deliver 3.25% savings on its budget, excluding high-cost drugs and devices and Clinical Negligence Premiums. Additionally, there is a further ask for delivery of 0.75% through Trustwide initiatives, including Procurement, Digital and Medicines. The Trustwide savings will be delivered by the key corporate lead, with support from the clinical divisions.

Central actions will be taken to deliver the further 1% (£7.8m) required which may include non-recurrent savings. Actions supporting this delivery will include further negotiations with the PFI, as well as reviewing rates for Agency and Bank. The Central savings will be delivered by the key corporate lead and will unlikely need support from clinical divisions due to their nature.

The approach started in 2022/23 for the governance around the delivery of savings through the Exec-led Financial Sustainability Board. This will continue alongside the monitoring of delivery through Divisional Review meetings on a monthly basis.

Weekly reports are produced and circulated to Divisional Operations Directors, Finance Business Partners and scheme leads, using information from the Savings Tracker to accurately report movement.

The Tracker holds project information on each scheme to improve confidence in deliverability. Information consists of project start/finish date, SRO lead name, scheme lead name, risks/issues.

### **3.4.7.4. Final 2024/25 position**

The delivery of savings at Month 11 is £21.1m, with a further £0.9m expected in Month 12. Any slippage beyond this would need to be added to the 2025/26 target and the clinical and corporate divisions have been made aware of this.

### **3.4.7.5. 2025/26 position for the Final return**

The savings identified for the Final return is £36.4m, thus 90% of the £40.6m target.

Of this £12.7m has been worked up in detail by divisions, with further savings identified from the following areas and plans are either in place for being worked up to deliver this level:

- £4.0m Procurement

- £0.5m Digital Transformation
- £0.5m Medicines Management
- £1.5m Fee paying
- £1.5m Productivity (cost reduction)
- £1.0m Admin review
- £0.3m Commercial

Further work is being undertaken to assess and capture opportunities from corporate benchmarking.

#### **3.4.7.6. Group Benefits and Savings**

The impact of the work underway on Group benefits and savings have not been included for the final submission. The investment requirements and associated savings are equal in 2025/26 so these budgetary changes can be reflected in year.

#### **3.4.8. Risks to the Income and Expenditure Position of the Trust in 2025/26 and mitigations to these**

The key risk is the delivery of savings. £40.6m needs to be delivered to ensure that NBT hits the breakeven position. Where divisions are unable to fully recurrently deliver the level of savings in year, they will need non-recurrent mitigations to counter any current year impact.

No detailed income schedules have been received from Associate commissioners. There is a risk that without the full detail of income expected that there is a misalignment of expectations.

Whilst the impact of the cap on Elective Recovery Funding is worked through, the ability to fully model the performance and financial trade-off that might be required drives a risk in both areas.

At this stage, there remains limited information shared from Specialised Commissioning. Whilst Elective Recovery Funding figures have been shared, no confirmation around significant national funding has been made. NBT is currently assuming funding in line with the 2024/25 position in the absence of further detail. The relationship with Specialised Commissioning continues to be positive, however there is pressure both on them and other areas of NHS England commissioning, to reduce costs and therefore they are scrutinising our spend, including drugs spend. The Trust will continue to work closely to with commissioners to minimise risks and to counter any challenges raised.

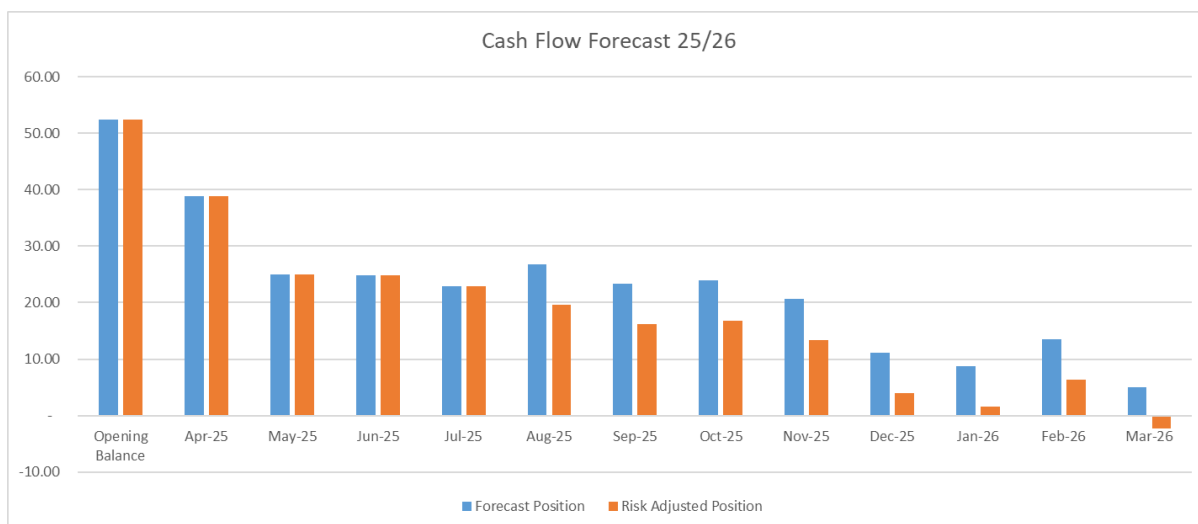
The Trust continues to work closely with the DH&SC on the impact of the 2023/24 change recognising PFI costs in relation to IFRS16. The Trust has recognised a pressure related to the calculation of Public Divided Capital in relation to the residual interest, as well as the inflationary impact on the PFI. Work will continue to model this for 2025/26 and reflect this within the position.

#### **3.4.9. Cash**

The cash balances for the Trust have been modelled in line with the planned I&E position and capital spend.

Cash is predicted to reduce in year. This is primarily driven by the payment of a high value invoices in the first quarter of the year relating to capital spend from the final quarter of 2024/25.

In addition, there are several impacts on cash due to technical non-cash income and expenditure items in particular the impact of the PFI (£7.2m).



Graph 1

The above graph shows a core cash forecast position giving a year-end cash balance of £5m and a risk adjusted position which shows the year-end cash position as £2m overdrawn.

In order to mitigate the risk of running out of cash and in a similar exercise to 2024/25, the Trust will work with the National team to obtain additional cash support in relation to shortfalls in cash due to PFI accounting. To this end the core position includes an assumption of £7.2m of cash support linked to the accounting of the PFI which is not included in the risk adjusted position.

Included within both models is an additional service payment for the PFI being paid in May.

The large decrease in cash in the first quarter in both scenarios is driven by the large value of capital invoices expected to be paid as a result of the high level of capital spend in March 2025 as mentioned above.

### 3.4.10. Capital

#### 3.4.10.1. ICS Capital Prioritisation

Since 2023/24, the CDEL (Capital Departmental Expenditure Limit) is issued to the ICB to allocate across the organisations in the system rather than to individual Trusts. This means that there is no longer any element of the capital envelope which is owned by any individual organisation. In addition, any future asset disposals or national funding will be allocated by the ICB to the area of highest priority rather than going directly to the organisation which generates it.

The ICB has developed mechanisms for agreeing priorities and distributing capital across the system. This involves a broad range of stakeholders dealing

with a relatively complex set of requirements and priorities as well as a high volume of potential schemes and a significantly over-subscribed capital budget.

### 3.4.10.2. NBT Funding position

Following the ICB process, the Trust currently has the following funding confirmed based on historic levels of depreciation:

	Value (£000)
Operational CDEL Envelope	23,742
Sustainability	2,233
Less System Brokerage – Agreed in 2024/25	(2,000)
Subtotal	23,975
Lease Capital	1,094
<b>Total</b>	<b>25,069</b>

Table 5

### 3.4.10.3. NBT capital allocation

There are a high level of commitments already identified against this envelope. The table 6 below shows the items that have already been approved at Capital Planning Group (CPG).

Further prioritisation is taking place to agree a full plan that matches current allocations.

Capital Project	Value (£000)
Bristol Surgical Centre	8,175
Level 0 CT Scanner	628
IR Lab 4 Replacement Bi Plane	355
Level 2 N Med	1,000
Cossham CT Scanner	1,000
Yate Plain Film Room	350
Cossham Plain Film Room	350
Hybrid Theatres	1,500
Mortuary Extension	1,500
SSD Washer Replacement	200
Pathology AHUs	2,426
NICU Ventilation	3,000
EPMA	662
Cyber Security Recovery, Protection & Backup Facility	36
High Speed Storage	85
PC Refresh	98
Replacement Capital Medical Equipment (CES)	1,010
PSDS Wave 3c (Excludes Salix spend)	850
Spend to be brought into 2024/25	(2,714)
<b>Subtotal</b>	<b>20,510</b>

Table 6

### 3.4.10.4. Over-programming

BNSSG has agreed an approach to overprogramming to ensure that any slippage is mitigated, and all capital allocations are fully utilised. To this end NBT will include a level of overprogramming as outlined in table 7 below.

Category	Depreciation Funding	Overprogramming	Sustainability Funding	Grand Total
Critical Infrastructure & Estates	5.8	3.2	0.0	9.0
Digital	1.0	1.1	0.0	2.2
Major Capital Schemes	7.2	0.0	0.0	7.2
Major Medical Equipment	5.2	0.0	0.0	5.2
Medical Equipment	0.6	3.0	0.0	3.6
Sustainability	0.9	0.0	2.0	2.8
Operational Capital	0.0	0.0	0.0	0.0
Lease	1.1	0.0	0.0	1.1
<b>Grand Total</b>	<b>21.7</b>	<b>7.4</b>	<b>2.0</b>	<b>31.1</b>

Table 7

### 3.4.10.5. National Capital Funding

In addition to the operational allocation based on historic depreciation, capital funding is available through national schemes. The allocation of this funding is to be prioritised at a ICB level for each organisation taking into account risks across the system. The Trust is actively engaging in this process.

The amounts of national funding provisionally allocated to the ICB are shown in the table 8 below. It is expected that there will be an additional allocation relating to digital schemes, but this is yet to be announced.

	Value (£000)
Return to Constitutional Standards – Diagnostics	500
Return to Constitutional Standards – Electives	13,750
Return to Constitutional Standards – UEC	10,250
Estates Safety	27,011
<b>Total</b>	<b>51,511</b>

Table 8

In order to maximise national funding received all items eligible for national funding are to be submitted even if they are already included in the operational capital plans shown above.

Once national funding has been awarded a risk-based prioritisation process will be carried out led by the ICB System Capital Board to allocate all remaining funds against unfunded items.

As a system, bids totalling £60.3m have been submitted against the £24.5m RtCS allocation and £37.4m against the Estates Safety allocation. The ICB Capital Board have decided to submit these lists in full rather than prioritise bids down to the level of the indicative allocations.

The below table 9 summarises the additional NBT schemes for which national funding has been bid for.

Category	Estates Safety	Diagnostics	Elective	UEC	Grand Total
Critical Infrastructure & Estates	7,086			5,000	12,086
Major Capital Schemes				1,341	1,341
Major Medical Equipment			4,800		4,800
Medical Equipment		596	90	700	1,386
Operational Capital		3,500		250	3,750
<b>Grand Total</b>	<b>7,086</b>	<b>4,096</b>	<b>4,890</b>	<b>7,291</b>	<b>23,363</b>

Table 9

#### 4. Summary and Recommendations

Trust Board are asked to:

- Note the Final position for NBT Business and Operational Planning for 2025/26. The plan will deliver a breakeven financial position and is compliant across performance metrics.
- Note that the Joint Chief Executive and Hospital Managing Director have approved the plan for submission to NHS England, in line with delegation from Trust Board, due to the timing of submission on the same day as the Board meeting.
- Note the amendment between the Headline and Final submission for key metrics to be submitted 27 March 2025.
- Note the approach to capital funding and allocation, including the over-programming.
- Note the risks included in the plan, and the approach to mitigating these.
- **Approve** the final budget for 2025/26, in advance of the start of the financial year.



## Appendix 1: Board Assurance Framework

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
<i>Governance</i>		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	Yes	Finance, Digital & Performance Committee (FDPC) received the draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board.  Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	Yes	Plans are developed from the bottom up - Divisional triumvirate develop plans to meet system and nationally led requirements. All savings plans are subject to quality assessment and cost pressures have received Executive Team sign off.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	Yes	The principle of living within our means and to deliver a compliant plan against the national priorities are fundamental in the prioritisation decisions made by the Board.
A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	Yes	Whilst QEIAs are not part of the development of the organisation's plans, they are embedded into the business case review and approval of CIPs, to ensure any planned changes have been assessed in both quality and equality impacts.
The organisation's plan was developed with appropriate input from and engagement with system partners.	Yes	System Finance, workforce and operational discussions contribute towards the Trust's planning position throughout the process.

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
<i>Plan content and delivery</i>		
<p>The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan ‘checklists’ and the use of benchmarking to identify unwarranted variation / improvement opportunities.</p>	Yes	<p>Finance, Digital &amp; Performance Committee (FDPC) received the Draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board.</p> <p>Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.</p>
<p>The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation’s operational, workforce and financial plans.</p>	Yes	<p>Detail of the savings required are set out in this paper, along with actions to deliver the required level. This is reflected in the operational, workforce and financial plans.</p>
<p>The Board is assured that any key risks to quality linked to the organisation’s plan have been identified and appropriate mitigations are in place.</p>	Yes	<p>Risks/Issues log are well understood both at a Trust and a system level.</p> <p>These are included in this report.</p>
<p>The Board is assured of the deliverability of the organisation’s operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.</p>	Yes	<p>Finance, Digital &amp; Performance Committee (FDPC) received the Draft Operating Plan in February which provided a comprehensive overview of the operational, workforce and financial plans at Headline submission stage. This was then reported upwards to Trust Board.</p> <p>Details of the Final submission to NHS England covering operational, workforce and financial plans have been scrutinised by the March FDPC and will be reported up to Trust Board.</p>

## Appendix 2: Health Inequalities focus

Priority focus	Guidance	2025/26 NBT Priorities and approach
<b>Data insights and sharing</b>	Reforming Elective Care: <ul style="list-style-type: none"> <li><i>demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes</i></li> </ul>	<ul style="list-style-type: none"> <li>Ethnicity recording – continue to aim for 80%+ of RTT waiting list. Remains a Top 10 data DQ for each division</li> <li>Exploring with ICB/UHBW a consistent approach to sharing and recording of data on housing status</li> </ul>
<b>Elective waiting times</b>	Reforming Elective Care: <ul style="list-style-type: none"> <li><i>undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches</i></li> <li><i>embed health inequalities data into performance reporting with a quarterly review at board level</i></li> </ul>	<ul style="list-style-type: none"> <li>Inequalities Performance <a href="#">dashboard</a> available to all specialties and Clinical Divisions for their review and consideration being given to Board level reporting via deep dives at the appropriate committees</li> <li>Assessment at Trust level shows no adverse 52+ week waits for Core20 and adverse additional average waiting time of 3 days for Core20 (down from 2 weeks additional in June 2024)</li> <li>Board subcommittees to consider deep dive sessions on inequalities as part of performance reviews</li> </ul>
<b>Outpatient access</b>	Reforming Elective Care: <ul style="list-style-type: none"> <li><i>develop and monitor action plans to reduce inequalities in access and quality of Care</i></li> </ul>	<ul style="list-style-type: none"> <li>All large outpatient specialties (10k+ per year) to set improvement target for DNA rate for IMD quintile 1 and Global Majority patient cohorts relative to overall DNA rate (i.e. to reduce DNAs and narrow the gap)</li> </ul>
<b>Prevention</b>	System priorities: <ul style="list-style-type: none"> <li>Tackling Tobacco Dependency (TTD) in maternity and inpatient settings (system ambition to reduce smoking prevalence below 5% by 2030)</li> <li>Healthy weight declaration being finalized</li> </ul>	<ul style="list-style-type: none"> <li>Roll out and embed admissions forms with smoking status, Very Brief Advice and referral to TTD</li> <li>Commit to Healthy Weight Declaration and develop action plan</li> </ul>

### Appendix 3: Productivity Pack

Measure	Measure description	National Published Opportunity £m	Trust Restated National Opportunity £m	Trust Targeted Opportunity £m	Trust Cash Releasing Opportunity £m	Provider Response	Actions in place
1	Non elective overnight stays	20.4	4.5	4.5		<ul style="list-style-type: none"> <li>- Internal processes reviewed to speed up to point of referral however success is determined on community provision to support NCTR.</li> <li>- Internal review against other acute trauma centres, Trust not outlier.</li> </ul>	<ul style="list-style-type: none"> <li>- UEC project around LOS to explore further opportunities.</li> </ul>
2	A&E and SDEC	2.4	2.4	2.4		<ul style="list-style-type: none"> <li>- Complexities of patients seen as major trauma centre.</li> <li>- Internal review against other acute trauma centres, Trust not outlier.</li> </ul>	<ul style="list-style-type: none"> <li>- Further review to understand opportunities.</li> </ul>
3	Elective Opportunity	18.0	3.9	1.0	0.5	<ul style="list-style-type: none"> <li>- Elective position under cap next year.</li> <li>- Projects in motion on areas such as theatre efficiency.</li> </ul>	<ul style="list-style-type: none"> <li>- Better understanding of the opportunity through business planning.</li> <li>- May be more productivity improvements compared to cash releasing.</li> </ul>
4	Outpatient Opportunity	64.3	2.0	2.0	1.0	<ul style="list-style-type: none"> <li>- Requested calculation to understand methodology.</li> <li>- Recognise opportunity and discussions within Finance and Operational colleagues to agree next steps.</li> </ul>	<ul style="list-style-type: none"> <li>- Outpatient NCC activity assessed, and top 10 specialities identified.</li> <li>- discussions with Ops to agree neared with divisions.</li> </ul>

Measure	Measure description	National Published Opportunity £m	Trust Restated National Opportunity £m	Trust Targeted Opportunity £m	Trust Cash Releasing Opportunity £m	Provider Response	Actions in place
5	Other Acute Activity	3.7	3.7	3.7	3.7	- Aligns with target set for support services division	
6	Temporary Staffing	8.8	8.8	2.5	2.5	- Agency spend is currently 1.5% of overall spend and significant action has been taken to reduce run rate. - Further opportunities under review in line with national guidance.	-Target further 30-40% reduction in agency in line with guidance, review against agency rules and changes in supplier for nursing and scientific. -Further controls across all temporary staffing.
7	Corporate Services	5.8	5.8	0.5	0.5	- Analysis completed across HR, IT and procurement. - In 23/24, for HR £3.1m related to international recruitment that was NR. IT teams has fluctuation in spend linked to capital projects. Further reviews in place.	- Review to understand position using the most current financial year and further discussions in areas of HR, IT, procurement and finance. - Opportunities to further review as part of group model discussions.
8	Medicines	1.5	1.5	0.4	0.4	- Ustekinumab started in November 24 and 100% switch expected by March 25. - Limited opportunity in 2025/26 unless further biosimilars.	- Continue to review as part of updates in guidance.
9	Commercial	5.1	5.1	4.0	4.0	- Adjusted target based on provider view, £3.7m already identified.	- Picked up through procurement CIP route.
<b>Total</b>		<b>130.0</b>	<b>37.7</b>	<b>21.0</b>	<b>12.6</b>		

#### Appendix 4: Workforce final submission and NBT's Contribution towards national guidance

	Mar-25	Mar-26	Variance
<b>Establishment</b>	<b>9,970</b>	<b>9,976</b>	<b>6</b>
<b>Total Substantive</b>	<b>9,525</b>	<b>9,605</b>	<b>80</b>
<b>Total Bank</b>	<b>673</b>	<b>613</b>	<b>-60</b>
<b>Total Agency</b>	<b>59</b>	<b>52</b>	<b>-7</b>
<b>Total Workforce</b>	<b>10,258</b>	<b>10,270</b>	<b>12</b>
<i>Of Which on Maternity Leave</i>	247	247	
<b>Over Establishment</b>	-41	-47	

Key Change	Workforce	Headline submission	Final submission
Elective Recovery - Bristol Surgical Centre Impact		Out	In – 273 wte
Headcount Reduction (wte and activity productivity gap, optimise substantive workforce, return spending on support functions to Apr-22 levels)		Out	In – 211 wte (31 wte existing vacancies and 180 wte staff in post)
Temporary Staffing Spend Reduction (Reduce temporary staffing spend - 30% Agency and 10% Bank spend reduction)		Out	In
Substantive Growth in Clinical Roles (optimise substantive workforce)		Yes – 136 wte	Yes – 87 wte
Over Establishment – Total Workforce (Workforce is maintained within the overall funded position (WTE and pay))		Yes – 160 wte	Yes – 71 wte

#### Additional Material Supply Adjustments

- NHS England Resident Doctor expansion has been reflected (2 Anaesthetics, 1 Intensive Care, 1 Renal, 2 Histopathology and, 6 Foundation Doctors) from August 2025.
- Reinvestment of temporary staffing budget to uplift substantive nursing establishments by 50 wte to recognise safe staffing and headroom requirements and to offset bank use once the posts are recruited to.
- Temporary staffing assumes the improvement seen year to date reflect in our month 8 and month 11 position continues and each profession then



contributes equally to a further reduction to deliver the required 10% reduction in bank and 30% reduction in agency expenditure in 2025/26.

### **NBT's Contribution towards national guidance - Wider People Factors**

Guidance requires Trusts to '**Systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes**'. We are already significantly progressed as an exemplar organisation in terms of the People Promise with national recognition for improvement in 2024. We also approved a refreshed Trust EDI plan in 2024 which incorporated the six high impact EDI actions published by NHS England.

**People Promise** – we are an exemplar organisation for People Promise implementation and have been nationally recognised by NHS Employers as one of the ten most improved organisations for staff engagement in 2024. Recognising the NHS England Planning priority to '**Systematically implement all elements of the People Promise to improve the working lives of all staff and increase staff retention and attendance and implement the 6 high impact actions to improve equality, diversity and inclusion. The evidence is clear that engaged, motivated staff improve productivity and patient outcomes**'. Significant work we have undertaken to enhance staff engagement and experience, we saw improvements in all our People Promise staff survey scores last year and achieved the highest score in the Southwest for most recommended place to work.

**'We do not Accept'** – we have delivered a successful 'we do not accept campaign' and are working to build on this success into 2025/26, we have agreed the key priority of continuing to enhance our organisational culture. We have a range of successful initiatives and interventions, and this is being consolidated into '*Living our Values*', which aims to embed the positive behaviours underpinning our Trust values. We will do this by making clear the expectations of our values and how they relate to behaviours including compassion, fairness, listening and learning. We will re-frame and simplify for staff, our support, guidance, systems, training and interventions for developing, building and maintaining a compassionate, civil and inclusive workplace culture.

**Equality, Diversity and Inclusion** - In November 2023, a new, 3-year EDI Plan was developed and agreed, which replaced the previous EDI Strategy "Valuing You". The 2023-2026 EDI Plan took account of 2022-23 EDI data and performance, our Patient First Strategy 'Proud to Belong' and the newly released NHSE EDI Improvement Plan with its 6 high impact areas. The Plan aimed to be ambitious, organisationally owned and practical, with clear metrics, regular progress reviews and opportunities to update as appropriate every 6 months. We reviewed the NHSE High Impact actions alongside our existing programmes of work and against where our own EDI data showed us that we need to improve. This led us to develop four key themes, which would be our core EDI areas of focus:



Since the development and implementation of our plan we have seen some positive improvements in many areas, particularly when looking at WDES and the experiences of our disabled staff. We have also seen improvements in our gender pay gap and in some of our WRES indicators, particularly in comparison with the national average position. We continue to review our data (qualitative and quantitative), report progress against the specific actions within the plan and refresh these as necessary.

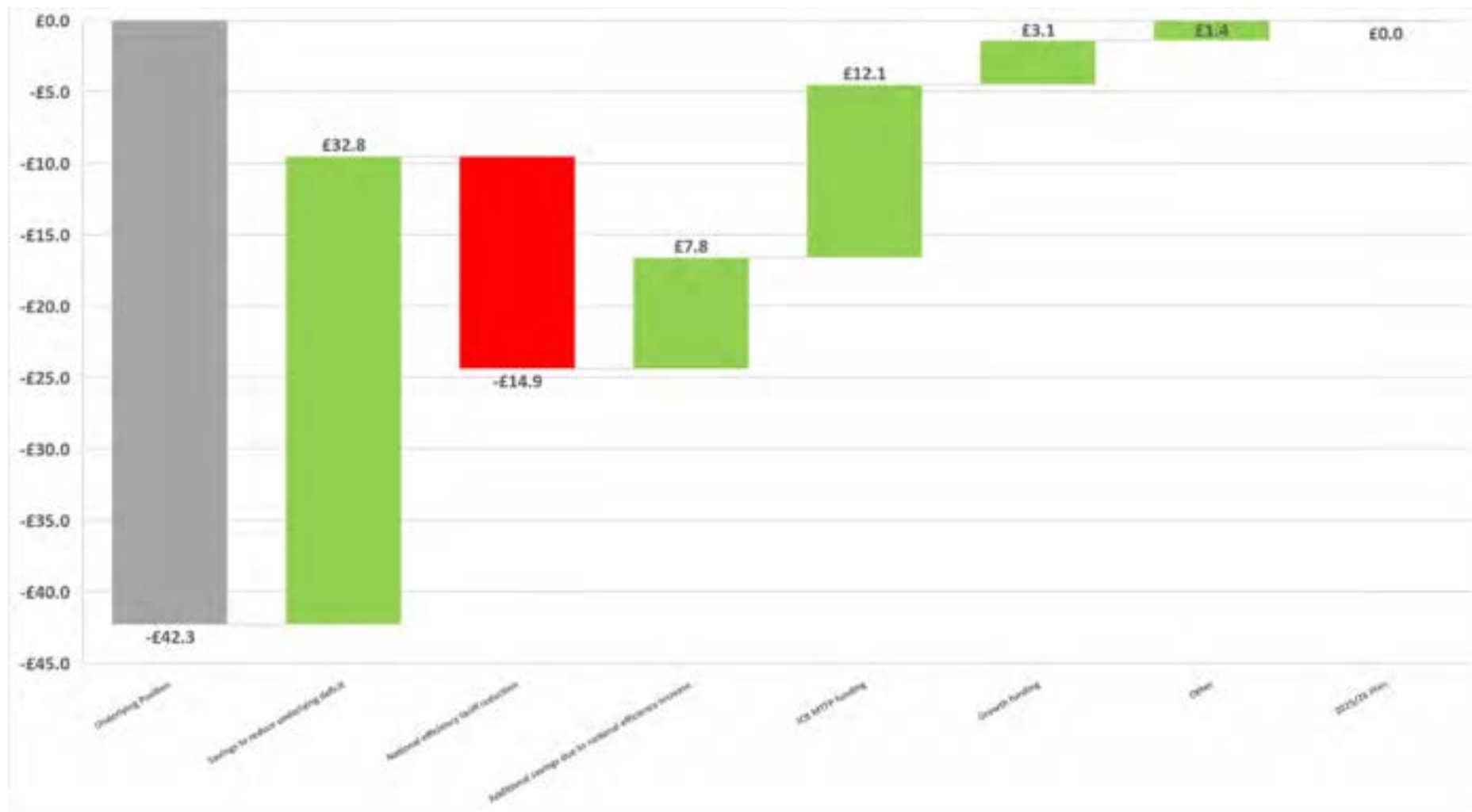
**Commitment to our Community** – As one of the largest employers here in Bristol, we are committed to having a truly diverse workforce that is representative of our local communities because we know that this enables us to deliver our aim of outstanding patient experience. We are tackling this as a key improvement priority under our patient first improvement approach. Our commitment is to increase employment opportunities for those who live locally, with a focus on ethnically diverse groups and in particular areas which are impacted by socio-economic disadvantage and experiencing inequalities. We have delivered a programme of work in 2024/25 which forms the foundation to our focus for 2025/26 including supporting candidates with active applications through the interview/onboarding process and ensuring our recruitment process is fair, using a patient first problem solving methodology and the aim of producing a toolkit for managers and ultimately improving our disparity ratio.

**Health and Wellbeing** - Sickness whilst target not achieved we have delivered statistically significant improvement in Trust absence rates and our wider Health and Wellbeing programme (aligned to our Clinical Strategy) continues to have a wide impact on staff engagement and attendance. Our 2025/26 Health and Wellbeing plan will continue to support staff to remain healthy and continue to provide outstanding patient care. We have developed a Staff Health and Wellbeing Plan 2025 to 2028 aligned to our People Strategy, Long Term Retention Plan and Clinical Strategy. The plan contains workstreams that will connect with our Hospital Group partners UHBW and will focus on four priority areas, Embed a culture of Staff Health and Wellbeing, Support Essential Health and Wellbeing, Improve Staff Physical Health and Wellbeing, Improve Staff Mental Health and Wellbeing. The plan also includes two golden threads linked to ICB workstreams, Health Inequalities and Trauma Informed Practice.

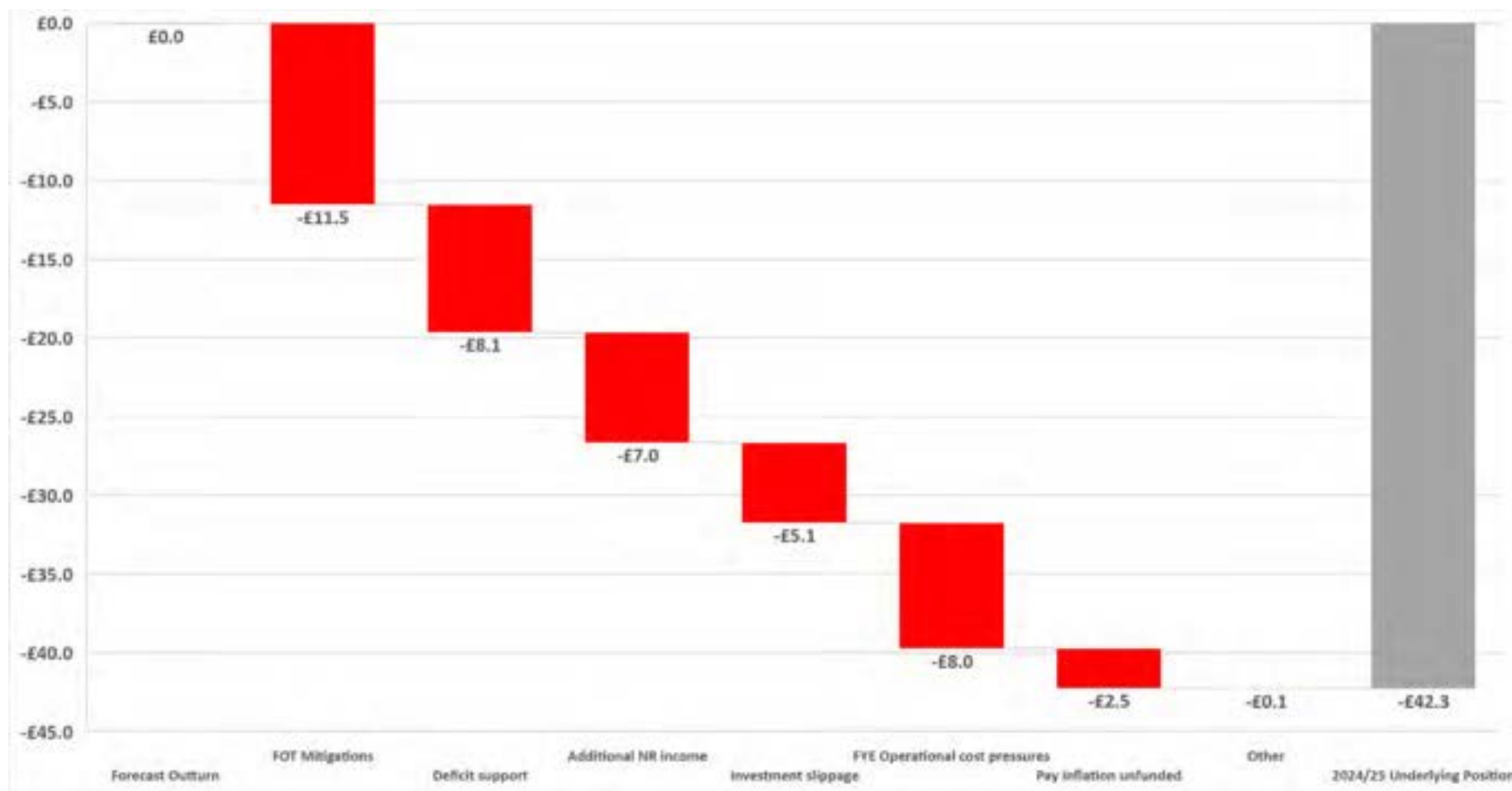
## Appendix 5 Final Budget 2025/26

(£'m)	Contract Income	Other Income	Pay	Non Pay	Surplus/(Deficit)
<b>2024/25 Plan</b>	<b>804.5</b>	<b>90.6</b>	<b>(552.0)</b>	<b>(343.1)</b>	<b>0.0</b>
2024/25 Non-recurrent items	(10.2)	(12.4)	(2.8)	(9.4)	(34.8)
Budget changes in year	34.7	11.3	(29.0)	(6.8)	10.2
<b>2024/25 Recurrent Budget (Month 9)</b>	<b>829.0</b>	<b>89.5</b>	<b>(583.8)</b>	<b>(359.2)</b>	<b>(24.6)</b>
Cost pressures	0.0	2.7	(0.2)	(19.7)	(17.2)
Other	5.0	9.4	(11.6)	(3.4)	(0.6)
<b>Underlying position</b>	<b>834.0</b>	<b>101.5</b>	<b>(595.5)</b>	<b>(382.3)</b>	<b>(42.3)</b>
Efficiencies	(14.9)	0.0	26.8	13.9	25.8
Pay and Non-pay inflation	30.8	0.0	(26.0)	(9.0)	(4.2)
Elective Recovery	31.2	(6.3)	(13.5)	(9.0)	2.5
Investments	0.0	0.0	(1.3)	0.0	(1.3)
Other	11.0	0.3	(4.8)	(4.7)	1.8
<b>2025/26 Recurrent exit budget</b>	<b>892.2</b>	<b>95.5</b>	<b>(614.3)</b>	<b>(391.1)</b>	<b>(17.7)</b>
Non-recurrent Contract Income	4.9	0.0	(1.0)	(2.0)	1.9
Non-recurrent budgets	8.1	2.5	(3.1)	5.7	13.3
Non-recurrent System mitigations	2.5	0.0	0.0	0.0	2.5
<b>2025/26 Budget</b>	<b>907.7</b>	<b>98.0</b>	<b>(618.3)</b>	<b>(387.4)</b>	<b>(0.0)</b>

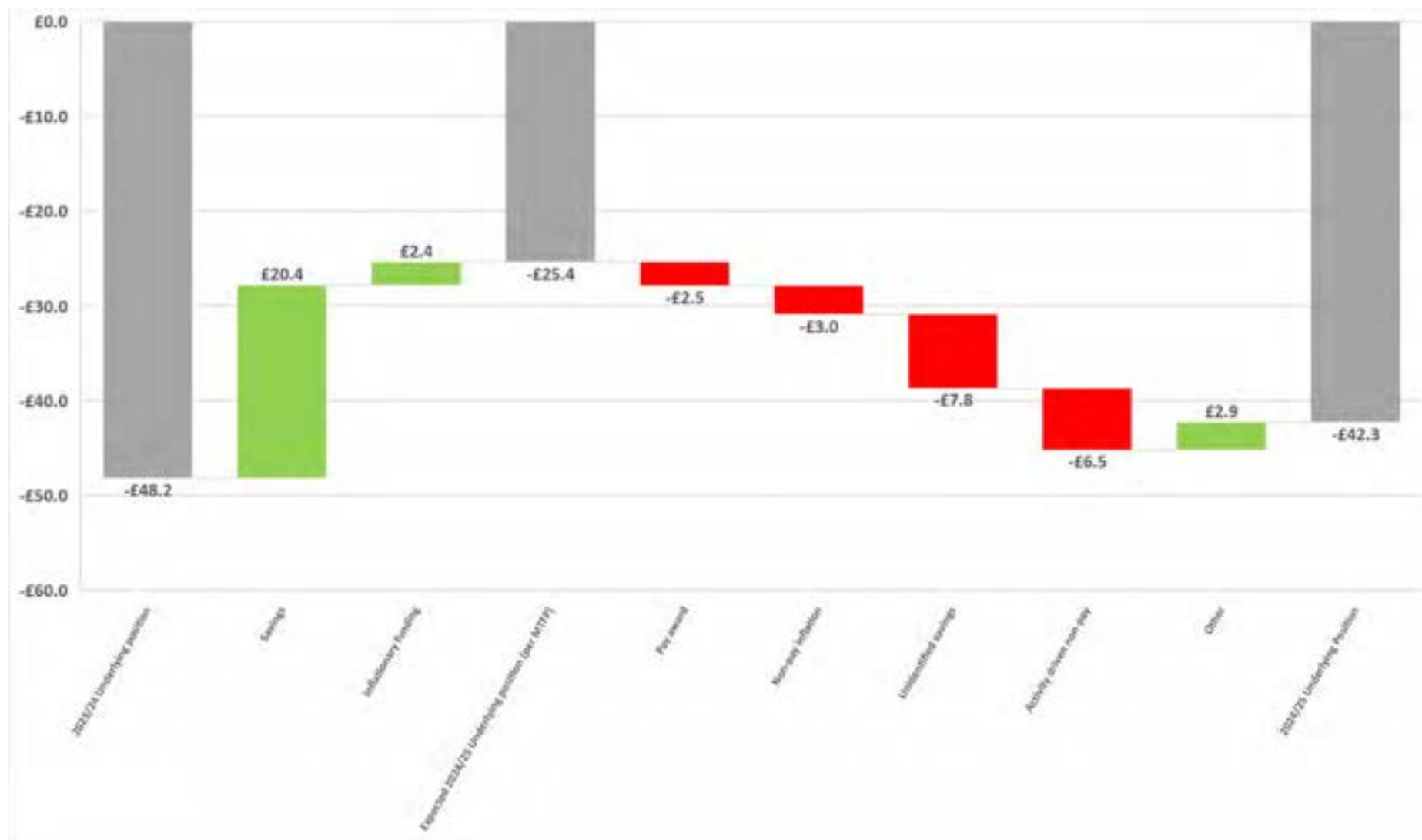
### Appendix 6 Financial Underlying Position to 2025/26 Final Plan



**Appendix 7 2024/25 Forecast Outturn to Underlying Position**



### Appendix 8 2023/24 Underlying to 2024/25 Underlying Position





## Meeting of the Board on 27 March 2025 in Public

<b>Reporting Committee</b>	<b>Quality Committee – 11 February 2025</b>
<b>Chaired By</b>	<b>Sarah Purdy, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Steve Hams, Chief Nursing Officer Tim Whittlestone, Chief Medical Officer</b>

<b>For Information</b>
<p>The Committee met on 11 February 2025 and received the following reports:</p> <ol style="list-style-type: none"> <li> <p><b>1. Longest-standing Risks Review:</b> this report provided an overview and details of the ten longest-standing risks in the purview of the Committee; risks 94 and 302 (Women’s and Children’s Health), 145 (Medicine), 166, 239, 264, 274, 277 and 290 (all ASCR) and 414 (Nursing and Quality). Risks 145 and 264 had recently been closed. Divisional representatives attended the Committee meeting to outline each risk and answer questions. The Committee heard that the longest-standing risks were not the same as the highest risks; they could be long-standing because there was no realistic way of resolving or mitigating them (for example because of the national shortage of paediatric radiologists, difficulties with sourcing necessary equipment, or the lack of space in the Neonatal Intensive Care Unit (NICU) and lack of funding for investment in new buildings). The Committee discussed each risk in detail. They heard that exceptional care was being delivered for patients at NBT (e.g. in NICU) despite the risks and that the vast majority of the risks listed were “acceptable risks”, some of them faced by all other Trusts, as well as by NBT (e.g. where there was a national shortage of equipment). They noted and were assured by the mitigating actions in place and noted that everything possible was being done to mitigate the remaining risks. The Committee welcomed the approach of deep-diving into the ten longest-standing risks. They suggested that a longest-standing risks review should be conducted annually and that, in future, it may also be useful to deep-dive into different risk categories. The Committee asked for a further update in due course on risk 94 (delays in obtaining and reporting some types of ultrasound scans in NICU due to the lack of an in-house paediatric radiology service).</p> </li> <li> <p><b>2. ePrescribe: Electronic Prescribing and Medicines Administration (EPMA) Project Update:</b> this report provided an update on progress with the EPMA project and its key workstreams, including information on governance, risks, mitigations and timelines. The Committee heard that the benefits of EPMA would be substantial, but it was not a cure-all, it was one of a number of measures, and it would not completely eliminate the risk of medication errors. EPMA fundamentally replaced paper drug charts and was predicted to lead to a reduction of around 30% of errors, most of which were caused as a result of human interventions, such as mis-spelling of medications, poor timing of prescriptions or incorrect dosage. The Committee noted that several different systems were used in different parts of NBT (e.g. Renal, Intensive Care and Maternity) and that EPMA was never designed to replace all other systems, but work would take place, after the initial roll-out of ePrescribe, to progress integration with other systems, in order to further minimise errors caused by system incompatibility or miscommunication. The Committee had already asked for further details of how EPMA would contribute to improving patient safety and was expecting further reports at future meetings on a safety barrier analysis and on red</p> </li> </ol>

wrist bands (which were used by some other Trusts to alert staff to patient allergies to medications).

3. **Integrating NHS Pharmacy and Medicines Optimisation (IPMO) Plan - Annual Update:** this report provided an overview of North Bristol NHS Trust's (NBT's) engagement with the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System's (ICS's) IPMO Plan and the progress being made. The Committee heard that, as a result of its previous feedback to the ICS Medicines Optimisation and Pharmacy System Leadership Group, the IPMO Plan had been incorporated into the ICS's Medicines Optimisation Joint Forward Plan and the BNSSG Medicines Optimisation Strategy. The Committee welcomed the assurance and the work planned and in progress, as well as the positive system working at Hospital Group level and ICS level.
4. **Patient Safety Quarter 3 report:** this report provided an overview of patient safety developments at NBT during the period October to December 2024, with incident numbers remaining generally stable and incidents focussed around service provision, falls and medication. Patient allergies to medication were the subject of considerable work across divisions and by the Medical Safety Forum. The Committee was also informed that an internal audit had been carried out on the implementation of the Patient Safety Incident Response Framework, with results to be reported to the Committee at a future meeting. The Committee noted and was assured by the update.
5. **Falls Prevention Update:** this report provided an overview of activity relating to falls prevention and management at NBT throughout 2024. The Committee heard that there had been a consistent decline in the number of inpatient falls at NBT over the last four years (a 23% improvement) with initial risk assessments being carried out more consistently, training being completed (with 91% compliance), work completed and ongoing to enhance understanding of falls-related issues and, critically, a high focus on falls risk management for patients aged over 70. The Committee discussed the data, which showed that most patients who fell were aged over 80, had no cognitive need and had not called for help. Hotspots (e.g. ward 32A) were being focused upon, as was risk-assessing waiting lists. The consequences of falls for very elderly people (e.g. increased frailty, pressure ulcers and others) were discussed, as was the higher rate of falls in Bristol per person (compared to other places). The Committee discussed the issue of no criteria to reside; many people who fell did not need to be in hospital and may be better cared for elsewhere. The Committee welcomed the reduction in falls and other updates and was assured by the report.
6. **Quality Priorities 2024/25: Quarter 3 Review:** this report provided a detailed update on progress against the Quality Priorities. Progress remained positive, with most projects rated green or amber and none rated red. The Committee heard details of projects including the Mortality Improvement Programme and Shared Decision-Making, and about the convergence between the Quality Priorities and the Patient First approach, with extensive work taking place to ensure all the Breakthrough Objectives were appropriately aligned and monitored. In terms of patient experience, more focus was being put on real-time insight and real-time feedback (including Patient Conversations) and the results of national patient experience surveys; benchmarking Family and Friends Test (FFT) data was proving less useful, as not all trusts used FFT. The Committee noted and was assured by the update, noting the alignment with UHBW.

7. **Healthcare Legal Department Biannual Update:** this report provided an update on the Trust's healthcare legal activity for Quarters 1 to 3 of 2024/25 and summarised lessons learned from claims and inquests. The Committee heard about the number and value of clinical negligence, employers' liability and public liability claims, and about inquests during the period, as well as other work of the healthcare legal team, providing in-house legal advice, training for staff in dealing with inquests and making considerable savings for the Trust, compared to the costs of external legal advice and representation. The Committee noted and was assured by the report.
8. **Perinatal Surveillance Quality Matrix (PQSM) Quarter 3 report:** this report summarised safety intelligence data for November 2024, providing assurance about the quality of maternity and neonatal services at NBT. The Committee heard about the term admission rate to NICU, which had decreased to its lowest rate (2.7%) for 11 months (a positive reduction) and about the small number of cases under, or referred for, investigation. The Committee heard that midwifery and nursing was currently recruited to vacancy and turnover, with some vacancies at consultant level. No moderate harm incidents had occurred in November. An increase in the number of stillbirths during recent weeks was discussed, with no themes or concerns about the care provided at NBT identified after thorough review. The Committee noted and was assured by the report (and by the additional assurance provided verbally by the Non-Executive Director Maternity Safety Champion).

The Committee also received an update on action taken since a discussion by the Trust Board in September 2024, specifically:

- that the Audit and Risk Committee on 7 November 2024 had considered and been assured about the reasons for and implications of the delays to the mortuary building works and
- that the People and EDI Committee on 16 January 2025 had considered and been assured about the review of the policy and process for re-checking staff who needed a DBS check (and in what circumstances that would happen in future).

The Chair of the Committee confirmed that she had reviewed the reports which had been submitted to the Audit and Risk Committee and to the People and EDI Committee, and she had been assured by those reports.

#### **For Board Awareness, Action or Response (including risks)**

The Committee took assurance from all the above items, on behalf of the Board. The Committee did not wish to escalate any issues to the Board for its attention.

#### **Key Decisions and Actions**

Not applicable.

#### **Additional Chair Comments**

None.

**Date of next meeting:** Thursday 13 March 2025

## Meeting of the Board on 27 March 2025 in Public

<b>Reporting Committee</b>	<b>Quality Committee – 13 March 2025</b>
<b>Chaired By</b>	<b>Sarah Purdy, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Steve Hams, Chief Nursing Officer Tim Whittlestone, Chief Medical Officer</b>

<b>For Information</b>
<p>The Committee met on 13 March 2025 and received the following reports:</p> <ol style="list-style-type: none"> <li> <p><b>1. Impact of Electronic Prescribing and Medicines Administration (EPMA) on the management of allergies in medication practice:</b> this report built on earlier reports submitted to the Quality Committee and provided an extended analysis of what safety barriers were anticipated following the implementation of EPMA. The Committee were informed that:</p> <ul style="list-style-type: none"> <li>• EPMA would benefit inpatients only and that some areas of the Trust would still use paper-based systems,</li> <li>• It was not possible to entirely remove the risk of a patient’s allergies not being identified and medication being administered incorrectly,</li> <li>• the system would remain reliant on clinician action and knowledge.</li> </ul> <p>The Committee received assurance that the system is designed to prevent prescriptions for patients with known allergies. However, it was acknowledged that this functionality relied on the accuracy of the input data. The Committee was also assured that the implementation of the system had been clinically led and that it represented the optimal prescribing solution, ensuring a single source of prescribing accuracy.</p> <p>The Committee discussed the digital opportunities for allergy verification through an application, including the implementation of alert prompts for validation. The Committee requested a further update in October, post implementation of the system and recommended that for further assurance it be included as part of the prioritisation process for the internal audit for 2026/27.</p> </li> <li> <p><b>2. Care Quality Commission (CQC) Assurance:</b> the Committee received an overview of the Trust’s actions to be “CQC ready” in line with the new CQC regulatory inspection regime and Single Assessment Framework. The Committee were informed that NBT was engaging with CQC representatives, attended quarterly CQC Executive Engagement meetings (the next of which was planned for 2 April 2025 at the new Bristol Surgical Centre) and was part of a CQC Engagement Pilot, and a Provider Network, with several other Trusts. The Committee discussed the ongoing Well-Led self-assessment work and were assured by the actions undertaken re continuous improvement. The Committee noted and were assured by the report.</p> </li> <li> <p><b>3. Trust Level Risks (TLRs) (Quality and Patient Safety) and Board Assurance Framework (BAF):</b> this report provided updated commentary on TLRs and the BAF as they related to this Committee’s remit. The Committee were informed of the ongoing work to review all the longest-standing risks and bring them to the relevant committees as well as the overall positive outcomes of the internal audit on risk management. The Committee received assurance re the dynamic risk management</p> </li> </ol>

process and discussed the ongoing work to mitigate and close risks, particularly regarding the risk of hybrid clinical noting (paper and electronic notes) for Medical, Nursing and AHP documentation.

4. **Perinatal Surveillance Quality Matrix (PQSM):** the Committee received the PQSM report and associated safety intelligence data for December 2024, which provided assurance about the quality of maternity and neonatal services at NBT. The Committee were informed about the term admission rate to NICU, which had increased slightly (to 4.1% against a national target of a maximum of 5%) and about the small number of cases under, or referred for, investigation. It was noted that no moderate harm incidents had occurred in December. The Committee discussed the increase in the number of stillbirths and received reassurance that no themes or concerns about the care provided at NBT identified was found after a thorough review. The Committee noted and was assured by the report.
5. The Committee also received upward reports from the Drugs and Therapeutics Committee, that Patient Safety Group, the Control of Infection Committee, and the Clinical Effectiveness and Outcomes Group. These provided assurance about progress being made with various workstreams within the purview of these committees and groups. Following discussion on the C .Difficile and needlestick injury rates, it was agreed that an assurance report would be brought to a future meeting. Overall, the Committee were assured by and noted the reports.

#### **For Board Awareness, Action or Response (including risks)**

The Committee took assurance from all the above items, on behalf of the Board. The Committee did not wish to escalate any issues to the Board for its attention.

#### **Key Decisions and Actions**

The Committee agreed to receive the following assurance reports at a future committee meeting:

- EMPA post implementation
- C .Difficile and needlestick injury rates

#### **Additional Chair Comments**

None.

**Date of next meeting:** Thursday 24 April 2025



## Meeting of the Trust Board on 27 March 2025

<b>Reporting Committee</b>	<b>Patient and Carer Experience Committee</b>
<b>Chaired By</b>	<b>Kelvin Blake, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Steven Hams, Chief Nursing Officer</b>

### For Information

The Committee met on 10 March and received the following reports:

1. **Patient Stories:** the Committee heard multiple patients' feedback about their experiences at North Bristol NHS Trust (NBT). The voice recordings came from Interactive Voice Messages (IVMs) left by patients who were contacted following their appointment or admission to give feedback to the Friends and Family Test (FFT).

The Committee positively noted that on average over 9/10 patients rated their care as good or outstanding and reflected on the key insights emphasising the importance of effective communication, decision-making transparency, and fostering a positive patient experience. The value of learning from positive experiences was noted and the Committee discussed future communication strategies to engage younger voices and diverse demographics. It was suggested that social media and alternative platforms could be utilised to ensure inclusivity in feedback collection.

The Committee received reassurance on the ongoing work by the Patient Experience Team in engaging with individuals with learning disabilities and mental health needs through proactive outreach. Additionally, positive feedback on volunteers was highlighted, with recognition of their vital role in supporting patients and families. Opportunities were identified to showcase these contributions during Patient Experience Week in April, incorporating personal stories and celebrating the impact of volunteers.

2. **Group Governance Development 2025 - Patient & Carer Representation:** The Committee received an update on the continuation of Patient & Carer Representation following the changes arising from the future Group Board structure and the discontinuation of the Patient and Carer Experience Committee. It was noted that patient experience and operational performance would be brought into the remit of the Quality & Outcomes Committee to align with UHBW, but it was recognised that it was essential the voices of patients was not diluted by these changes. The Committee were informed of the key messaging following the engagement session hosted by the Group Chair with the Patient and Carer Partnership Group in March. Additionally, the Committee were advised of the next steps which included, having a committed board development session which focused on patient and carer experience, setting up a Patient Advisory Group and sharing expertise across both patient and carer engagement teams.

Discussion focused on the importance of practical actions that drive meaningful change, ensuring patient feedback was taken seriously. The



Committee were assured that regardless of structural changes, a robust and well-resourced framework would remain in place, with a commitment from leadership to uphold its effectiveness. The structure would focus on practical impact rather than governance, ensuring patient experience remained a priority. Concerns were raised about losing the collective input of the group, but reassurance was given that key functions would be maintained, with executive support and the ability to escalate matters to the Trust Board.

3. **Patient Experience Risk Report:** The Committee received the report which set out the Patient Experience Trust Level Risks. The Committee discussed the risks in depth and received assurance regarding the mitigating actions in place. In particular, the Committee discussed the risk regarding the transfer of care for mental health patients and noted the complexity of patients' needs, the shortage of mental health beds in the system and the ongoing active engagement with the ICB to mitigate and reduce the risk. It was recognised that Patient Experience Risks were also reported via the Quality Committee in addition to the oversight provided through the Risk Management Group.
4. **Patient and Carer Experience Strategy: 2025/26 Outline Delivery Plan:** the Committee received the report which set out the outline delivery plan for the Patient and Carer Experience Strategy in 2025/26. It was noted that there were 42 objectives within the strategy which were under four commitments:
  1. Listening to what patients tell us
  2. Working together to support and value the individual and promote inclusion
  3. Being responsive and striving for better
  4. Putting the spotlight on patient and carer experience

The Committee welcomed the positive progress of patient and carer experience over the previous two years under the Patient and Carer Experience Strategy. Discussion focused on the delivering the plan and the commitments whilst also enabling and supporting strategic and group model alignment. It was recognised that this would place capacity demands upon the teams leading this work and some in year flexing might be required.

5. **Mental Health Strategy: Delivery Plan Update:** The Committee received the report which provided an update on the delivery plan of the Mental Health Strategy that was approved by the Trust Board in July 2024. It was noted that delivery for year one was on track for the four key priorities identified in the strategy. These are as follows:
  - Timely and responsive access to mental health service for all.
  - Support our staff to deliver effective care and outstanding experience for mental health patients.
  - Support our staff with their mental health needs.
  - Working in partnership to tackle health inequalities associated with mental health.

The Committee discussed the ambitious nature of the plan, emphasising the importance of setting realistic commitments with an honest RAG rating to ensure achievability. The Committee noted the importance of raising

<p>awareness, advocacy and maintaining ambition, even where full achievement may not be possible due to external or financial constraints.</p> <p>6. A highlight report from the <b>Patient and Carer Experience Group</b>, where all workstreams were rated green.</p> <p>7. A highlight report from the <b>Learning Disability and Autism Steering Group</b>, where all workstreams were rated green.</p>	
<b>For Board Awareness, Action or Response (including risks)</b>	
<p>None of the items above require specific Board action or response. This report informs the Board of the activities undertaken by the Committee on its behalf. Board should note that this was the last Patient and Carer Committee meeting.</p>	
<b>Key Decisions and Actions</b>	
None.	
<b>Additional Chair Comments</b>	
None.	
<b>Date of next meeting:</b>	Not Applicable – this was the last Patient and Carer Experience Committee meeting.

## Meeting of the Board on 27 March 2025 in Public

<b>Reporting Committee</b>	<b>People and Equality, Diversity and Inclusion (EDI) Committee</b>
<b>Chaired By</b>	<b>Kelvin Blake, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Peter Mitchell, Interim Chief People Officer</b>

### For Information

The Committee met on 11 March 2025 and received the following reports:

1. **Chief People Officer Update** - this was a verbal update which focused on:
  - The collaborative work taking place across NBT and UHBW, and with Teneo, to advance the Hospital Group. It was noted that it would be formally launched in April with a Group Board meeting and the go-live of Cardiology as the first single managed service. Additionally there would be potential changes to committees and Executive management structures to support the Group work.
  - An update on the financial position for 2024/25 and the ongoing work to develop the plan for 2025/26. The Cost Improvement Plans and recruitment controls were discussed.
  - The changes to the Employment Rights Bill. It was noted that an update on the implications for NBT would be reported at a future meeting.
  - The excellent engagement of NBT staff in the latest national staff survey, with the 62% response rate target and positive results.

Discussion focused on headcount and vacancy controls and the Committee noted the importance of communication to alleviate concerns.

2. **Trust Health and Safety Committee Update** - this report provided assurance on the effectiveness of the oversight and management of Health and Safety in the Trust. Updates were provided on:
  - internal and external audits carried out or planned across the Trust Estate, particularly the internal fire audit and the external central sterile services department (CSSD) audit.
  - health and safety risks and the ongoing mitigation work
  - recent RIDDOR Incidents (with numbers reducing) and
  - violence and aggression incidents

The Committee received reassurance on the progress of the actions against the audits.

3. **Risk Management** - the Committee received a report on Trust Level Risks (TLRs) across its areas of responsibility, including health and safety and workforce risks, and reviewed relevant Board Assurance Framework (BAF) risks. It was noted that the workforce BAF entry had been updated and would be taken to April's Board meeting.

The Committee were joined by the Divisional Directors of Nursing and engaged in a robust discussion on longstanding, complex risks that have been challenging to address. It was recognised that these issues remain a priority, with a commitment to ensuring the best outcomes for both patients and staff.

Following a thorough discussion of each risk, the Committee received assurance that appropriate mitigating actions were in place and that the risks were subject to ongoing review.

4. **Operational Workforce Update** - The report provided assurance in relation to the delivery of operational workforce priorities. The ongoing work on Commitment to the Community targets was highlighted, specifically:
- the refreshed target for the disparity ratio which was now 1.55 for 2025/26. It was recognised that this was now in line with a deeper understanding of the drivers of disparity and the interventions and time required to effect change,
  - the improvement target for 2025/26 had been set at 38% for the percentage of recruitment into target roles from 30 of most challenged communities across BNSSG.

The Committee welcomed the report and the positive progress in retention and turnover. Discussion focused on the short and long term sickness rates and the actions being undertaken with the divisions to manage these. It was noted that the civility and respect framework would be incorporated into the “Living our Values” work.

The Committee also discussed the concerns regarding changes in disparity ratios and the underlying factors influencing target adjustments. The Committee were reassured that efforts were underway to promote career pathways, engage with local communities, and develop talent internally to address these disparities. The Committee emphasised the importance of ongoing monitoring, addressing root causes, and ensuring targeted interventions to drive meaningful change.

5. **National Staff Survey Results**– The Committee received the report which set out the key elements of the 2024 National Staff Survey (NSS) and highlighted areas where NBT has performed well and areas of focus for 2025-26. Overall, it was noted that the 2024 National Staff Survey results presented a largely positive picture, with our best response rate ever (62%) and improving People Promise scores.

The Committee welcomed the results and noted the positive feedback on appraisals across the board, with particularly positive improvement in the experience of Global Majority staff. The Committee were pleased to note that the trust benchmarked well against similar trusts in the region.

The Committee raised concerns around staff experiencing violence and aggression from patients and recognised the complexity of the issue. The Committee discussed the importance of acting on the feedback and ensuring the route cause is addressed and that resources were put in place to ensure staff were supported.

It was noted that this would be presented as a separate item to the Board.

6. **EDI Plan update** – The Committee received the report which set out the progress in implementing NBT’s 3-year EDI Plan. A detailed summary of progress against each of the four EDI areas of focus was provided.

The Committee welcomed the update and discussed how the next iteration would be aligned with UHBW.

7. **Living our Values** – The Committee received a verbal update on the “Living our Values” work, which was a programme of work aimed at embedding the positive behaviours underpinning the Trust’s values into employees’ working lives.
8. **People Oversight Group Upward Report** - The Committee also received an update on the deliberations and decisions of the People Oversight Group, which was a monthly Executive level group chaired by the Chief People Officer with senior level membership from across clinical, medical, operational, finance, digital, facilities, other corporate services and people teams. The Committee noted and welcomed the update.

#### **For Board Awareness, Action or Response (including risks)**

The Committee took assurance from all the above items, on behalf of the Board. The Committee did not wish to escalate any issues to the Board for its attention.

#### **Key Decisions and Actions**

None

#### **Additional Chair Comments**

None

**Date of next meeting:** Thursday 22 May 2025

## Meeting of the Board on 27 March 2025 held in Public

<b>Reporting Committee</b>	<b>Finance, Digital &amp; Performance Committee</b>
<b>Chaired By</b>	<b>Richard Gaunt, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Elizabeth Poskitt, Chief Finance Officer Nick Smith, Interim Chief Operating Officer</b>

<b>For Information</b>
<p>The Committee met on 18 March 2025 and received the following reports:</p> <ol style="list-style-type: none"> <li> <b>1. Performance Report:</b> this was an update on the latest Trust performance position against a range of key national metrics and the most recent performance data: <ul style="list-style-type: none"> <li> <b>• Unscheduled Care (UEC):</b> achieving the year-end target of 78% remained challenged, as a result of: <ul style="list-style-type: none"> <li>○ the continued increase in Emergency Department attendances</li> <li>○ the continued No Criteria To Reside (NCTR) position (currently at 22%), with no progress towards reducing it to 15%</li> <li>○ the significant rise in flu and other respiratory infections, as well as Norovirus presentations since December</li> </ul> </li> <li> <b>• Planned Care:</b> the Trust had been successful in delivering its 65-week clearance operational plan and the 52-week backlog had seen a further significant reduction, with a realistic ambition of achieving zero 52-week waiters by the end of April (and the national target of no more than 1% of people on the waiting list waiting more than 52 weeks already exceeded) </li> <li> <b>• Diagnostics:</b> the Trust continued to meet the constitutional 6-week standard, exceed the national target and deliver a zero &gt;13-week breach backstop </li> <li> <b>• Cancer:</b> the Trust had now been compliant against the 28-day Faster Diagnosis Standard for eight consecutive months. After two full months of compliance with the 62-day Combined Standard, performance had dipped in January, but actions were in place to recover against the March requirement. </li> </ul> <p>Discussion focused on the No Criteria To Reside position, and the cost that was being incurred by NBT because of the current high levels. NEDs requested that the incurred cost for NBT related to NCTR be calculated and provided. This was to enable NCTR costs to be understood and then they could be taken into account in financial decision making, as well as in other decision making. The Committee welcomed the report, the improving performance and the efforts to sustain that improvement.</p> </li> <li> <b>2. Operational/Business Plan 2025/26:</b> the final Operating Plan and updated Business Planning paper, for approval by the Joint Chief Executive and the Hospital Managing Director under delegated powers (subject to later submission to the Board), prior to its submission to NHS England on 27 March 2025. The Trust plan was for operational compliance for elective and cancer performance by the end of March 2026 and the financial plan involving breakeven for NBT and the whole of the BNSSG system. The workforce plan included the impact of the Bristol Surgical Centre and headcount reductions required to deliver the plan. Confidence was high that the performance and financial targets would be met, with assumptions (as before) around the value of Elective Recovery Funding and NC2R being reduced to 15% (and other assumptions detailed in the plan). </li> </ol>



The Committee heard and discussed substantial detail and data on performance, finances, the budget and workforce, including how the operating, finance, budget and workforce plans had changed between the earlier headline version and the final submission. They also discussed the savings planned, productivity issues and the Board Assurance Framework relating to the plan, which gave assurance on governance, plan content and delivery of the plan. Discussion also took place about the opening date of the Bristol Surgical Centre, the shortage of community beds (linked to the NC2R position) and potential solutions in the wider system, the proposed headcount reduction and the mechanics of that, and the key risks to achieving the plan. The Committee endorsed the plan, acknowledging that it would be approved under the delegated powers described above and also submitted to the Board.

3. **Capital Programme Update:** this report detailed the planned out-turn for the 2024/25 Capital Programme and the Capital Plan for 2025/26. The Committee heard that the capital projects proposed for 2025/26 would help address key Trust risks and were, in the main, low-volume, high-value investments, including CT scanners, other imaging equipment and fire risk solutions, with specific funds for the Elective Centre (now known as the Bristol Surgical Centre), mortuary extension, digital investments (such as EPMA) and other items.

Confidence was high that the capital programme and plan would be achieved for both 2024/25 and 2025/26, with appropriate milestones and mitigations in place. NBT had been allocated an initial envelope of £21.742 million for 2025/26, with 25% over-programming allowed (taking the total to £27.178m), with a further £11m yet to be allocated by the Integrated Care Board and approximately £51m held by NHS England and open for bids (several of which NBT had submitted). The Committee noted the update on the 2024/25 Capital Programme and recommended the 2025/26 Capital Plan (totalling £31.11m, taking into account slippage from 2024/25 into 2025/26 and earmarked sustainability funding) for approval under delegated powers, as described in section 2 above, as part of the Business/Operating Plan.

4. **Finance Report, month 11:** the key points of this report (listed below) were noted and the breakeven prediction was welcomed:
- the financial plan for 2024/25 in Month 11 was a £0.8m surplus, with a £2.3m surplus actually achieved (£1.5m better than plan)
  - in the year to date, the Trust was reporting a £1.0m adverse variance, driven by in-year Cost Improvement Plan (CIP) non-delivery, non-pay pressures and overspends on temporary staffing from April to July
  - an increased level of confidence in the Trust achieving breakeven due to the actions taken in-year
  - the Month 11 CIP position showed £21.1m schemes delivered, with a further £0.9m in implementation and planning
  - cash at Month 11 amounted to £56.9m, a reduction of £5.8m from March 2024, driven by the Trust's underlying deficit and capital spend.

The full report is appended (see **Appendix 1**).

5. **Green Plan bi-annual update and Sustainability Policy:** this report updated the Committee on NBT's progress against the Green Plan Delivery Plan targets since 1 April 2024, detailing key opportunities and challenges, and included the Integrated

Care System (ICS) Sustainability Policy, defining system responsibilities, objectives and commitments.

The Committee heard about the Trust's various achievements and successes, including in terms of the carbon footprint reduction achieved, and about its plans going forward to sustain the good work so far. Discussion took place about the reality of achieving the 2030 Net Zero target and the need for significant capital investment in order to do so, as well as more success with Green Travel (e.g. more people using public transport). The Committee noted and welcomed the report and progress; and approved the policy and the proposed approach to sustainability objectives.

6. **Information Management and Technology (IM&T) Digital Operational and Digital Transformation Performance:** this report, from the IM&T Operational Management Board and the Digital Hospital Programme Board updated the Committee on IM&T risks and developments. The Committee heard about some of the risks, and about a recent major system outage incident, which caused intermittent but significant impacts on devices and staff across NBT. The causes and phases of the incident were outlined, as was the response to it and the lessons learned from it. The Committee also heard about ongoing digital projects including ePrescribe (electronic prescribing), which would have a significant impact on the way medicines were prescribed across the Trust, and the ongoing exploration of potential artificial intelligence (AI) advances in relation to admin and clerical processes (e.g. patient appointment letters).

The Committee welcomed the report and developments, with a request for more clarity on project timescales in future reports.

7. **Risk Report:** this report provided an update on relevant risks within the Committee's purview including Trust Level Risks (TLRs) and extracts of the Board Assurance Framework (BAF). The report also included details of the four longest-standing risks within the Committee's purview, namely:

- Risk 1681: imaging equipment approaching end of life
- Risk 1757: vacant Consultant posts: Haempath team
- Risk 988: Cancer Services: insufficient capacity.
- Risk 1587: failure of chillers: Pathology Phase 2 building.

The Committee heard about factors contributing to those risks, as well as current controls, gaps, actions and potential routes to resolution of those risks. The Committee discussed the risks in detail and welcomed the opportunity to do so.

8. The Committee also received and reviewed:

- a contract recommendation (which is referred to in a separate upward report from this Committee to the Board meeting in private, due to the confidential nature of the information contained in that report)
- an update from the Business Case Review Group, which the Committee noted
- a quarterly Theatre Productivity report (key performance indicators, cases per day and capped theatre utilisation), which the Committee noted.

#### **For Board Awareness, Action or Response (including risks)**

Nothing specific beyond the above.

<b>Key Decisions and Actions</b>	
<p>The Board will receive the Business Plan as a separate item on its 27 March agenda. The month 11 finance report is appended to this report for the Board's information.</p>	
<b>Additional Chair Comments</b>	
<p>The 2025/26 Final Operational Plan is probably the most challenging to date and it will be important to maintain tight control, particularly in Q1:</p> <ul style="list-style-type: none"> <li>(1) NCTR is assumed to fall from 22% currently to 15%, but the financial impact of not achieving this (largely system driven) is not clear</li> <li>(2) Whilst CIP plans have been worked up for £32.6m of divisional savings, in year achievement of full savings is challenging</li> <li>(3) Achievement of remaining £7.8m of CIP cost reductions are still being worked on</li> <li>(4) Due to the block nature of certain income streams, productivity efficiencies do not always result in bottom line savings</li> <li>(5) Workforce WTE shows a year-on-year increase, largely driven by BSC increase of 273 and clinical roles of 136, but also a CIP/cost reduction of 255 mainly driven by a freeze on external recruitment for all non-clinical posts and increased bank/ agency controls.</li> </ul> <p>On the Green Plan, it is unlikely net carbon zero will be achieved by 2030.</p>	
<b>Date of next meeting:</b>	20 May 2025.

<b>Report To:</b>	Trust Board		
<b>Date of Meeting:</b>	27 March 2025		
<b>Report Title:</b>	Finance Report for February 2025 (Month 11)		
<b>Report Author:</b>	Simon Jones, Assistant Director of Finance – Financial Management		
<b>Report Sponsor:</b>	Elizabeth Poskitt, Chief Financial Officer		
<b>Purpose of the report:</b>	<b>Approval</b>	<b>Discussion</b>	<b>Information</b>
			x
	The purpose of the report is to inform the Trust Board of the Month 11 financial report.		
<b>Key Points to Note</b> <i>(Including any previous decisions taken)</i>			
<p>The financial plan for 2024/25 in Month 11 was an £0.8m surplus. The Trust has delivered an in-month surplus of £2.3m, £1.5m favourable to plan. This has been driven by a favourable contract income position due to the in-month recognition of funding related to winter pressures and group support, partially offset by undelivered CIP .</p> <p>Year to date, the Trust is reporting a £1.0m adverse variance. This has been driven by in year CIP non-delivery, non-pay pressures and overspends on temporary staffing from April to July.</p> <p>The actions undertaken to recover the financial position in year and secure further funding have resulted in increased confidence that there is a route to breakeven.</p> <p>The Trust cash position at Month 11 is £56.9m, a reduction of £5.8m from March 2024. This is driven by the Trust's underlying deficit and capital spend.</p> <p>The Trust has delivered £21.1m of completed Cost Improvement Programme (CIP) schemes at Month 11. There are a further £0.9m of schemes in implementation and planning. CIP non-delivery within the year-to-date position relates to the in-year impact of schemes delivering on a recurrent basis.</p> <p>The Trust is forecasting to deliver a capital expenditure outturn at year end equal to the level of funding available through the Trust's core capital envelope and by national funding.</p>			
<b>Strategic Alignment</b>			
This report aims for outstanding patient experience and links with priorities and projects within Patient First, particularly the improvement priority for Sustainability – making best use of our limited resources.			
<b>Risks and Opportunities</b>			
<p><b>Key risks:</b></p> <ul style="list-style-type: none"> <li>Capital expenditure of £28.5m is required in the final month of the year in order to utilise the Trust's full allocation. Plans are in place for this expenditure, however this constitutes a large proportion of annual capital spend.</li> <li>In year, whilst pay costs year to date exceed plan, new controls introduced in August have delivered a reduction in agency and bank spend from August to February. These measures need to continue to deliver for the remainder of the financial year.</li> </ul>			

- Continued focus on delivering in year savings and containing non-pay spend are also required to ensure breakeven.

### Recommendation

This report is for Information.  
Trust Board are asked to note the report.

### History of the paper (details of where paper has previously been received)

Executive Management Team	N/A
Senior Leadership Group	N/A
Finance, Digital & Performance committee	20 March 2025
Trust Board	N/A
<b>Appendices:</b>	<i>Appendix 1 – Finance Report Month 11</i>

## Finance Performance Report

### Trust Board: Month 11 2024/25

Author: Simon Jones (Assistant Director of Finance)

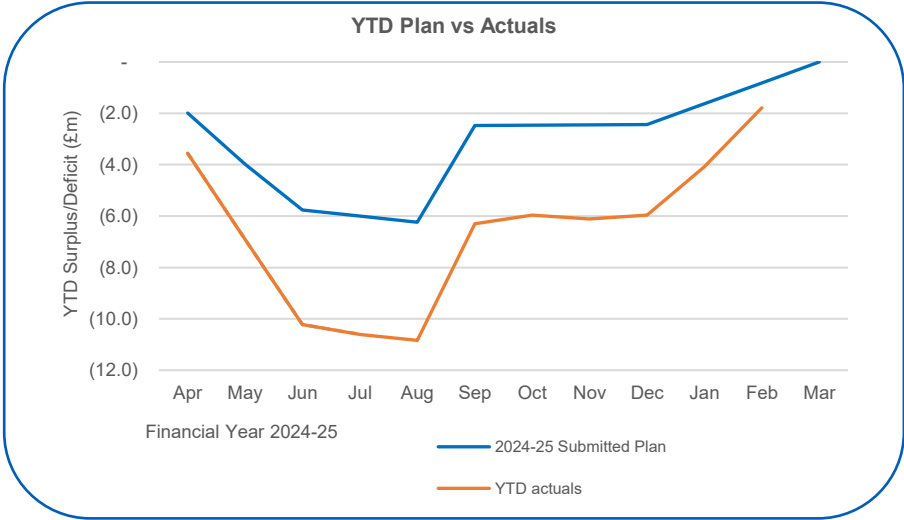
Sponsor: Elizabeth Poskitt (Chief Finance Officer)





# Finance Summary

	Month 11			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	75.6	82.6	7.0	795.3	818.2	22.9
Income	1.1	9.3	8.2	49.0	95.5	46.4
Pay	(47.6)	(52.4)	(4.9)	(530.1)	(550.6)	(20.5)
Non-pay	(28.3)	(37.2)	(8.9)	(315.0)	(364.9)	(49.9)
<b>Surplus/(Deficit)</b>	<b>0.8</b>	<b>2.3</b>	<b>1.5</b>	<b>(0.8)</b>	<b>(1.8)</b>	<b>(1.0)</b>



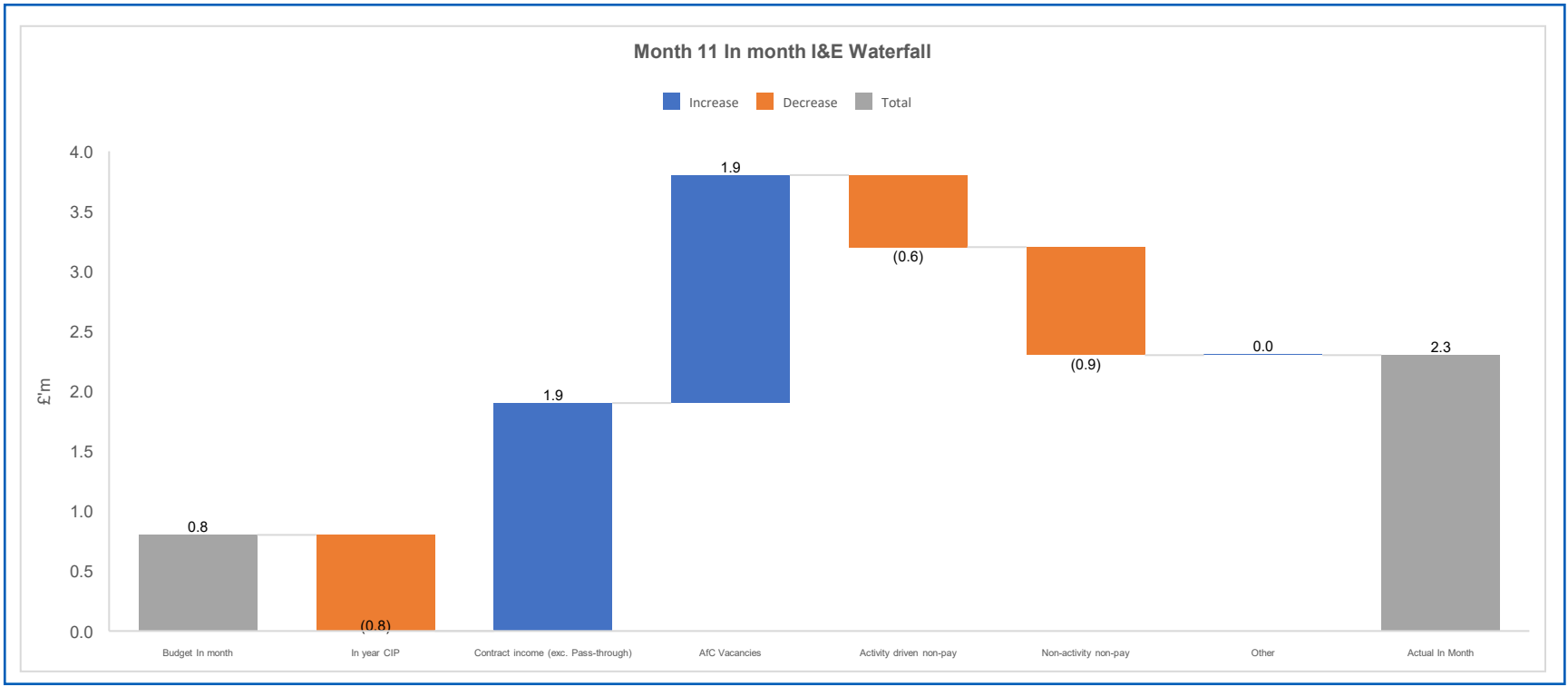
**Key messages:**

- The financial plan for 2024/25 in Month 11 was an £0.8m surplus. The Trust has delivered an in-month surplus of £2.3m, £1.5m favourable to plan. This has been driven by a favourable contract income position due to the in-month recognition of funding related to winter pressures and group support, partially offset by undelivered CIP .
- Year to date, the Trust is reporting a £1.0m adverse variance. This has been driven by in year CIP non-delivery, non-pay pressures and overspends on temporary staffing from April to July.
- The actions undertaken to recover the financial position in year and secure further funding have resulted in increased confidence that there is a route to breakeven.
- The Trust cash position at Month 11 is £56.9m, a reduction of £5.8m from March 2024. This is driven by the Trust's underlying deficit and capital spend.
- The Trust has delivered £21.1m of completed Cost Improvement Programme (CIP) schemes at Month 11. There are a further £0.9m of schemes in implementation and planning. CIP non-delivery within the year-to-date position relates to the in-year impact of schemes delivering on a recurrent basis.
- The Trust is forecasting to deliver a capital expenditure outturn at year end equal to the level of funding available through the Trust's core capital envelope and by national funding.

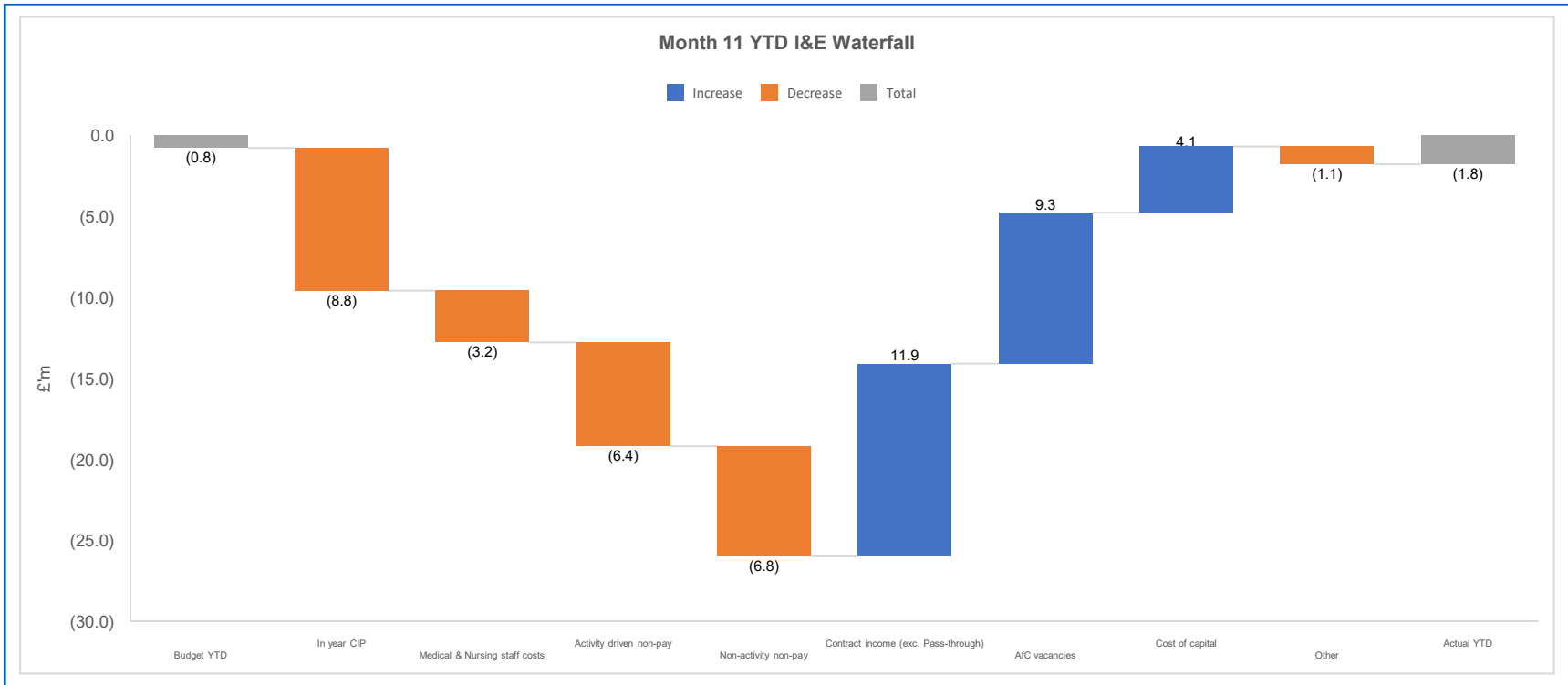
**Key risks:**

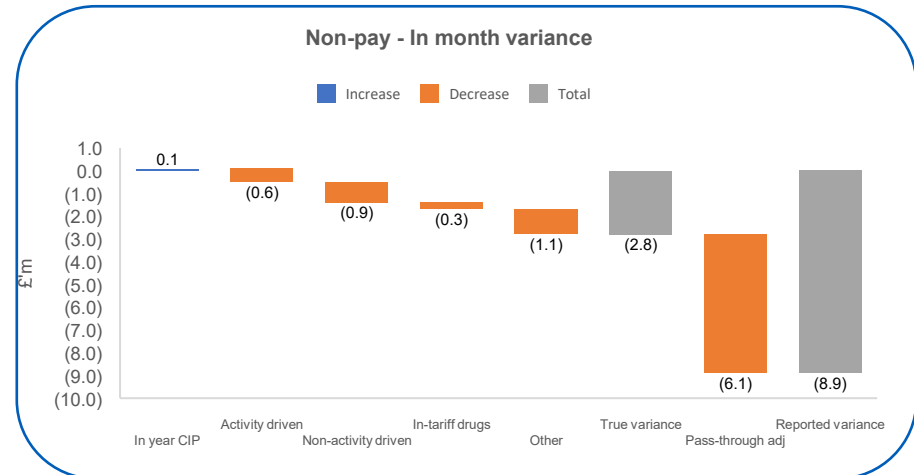
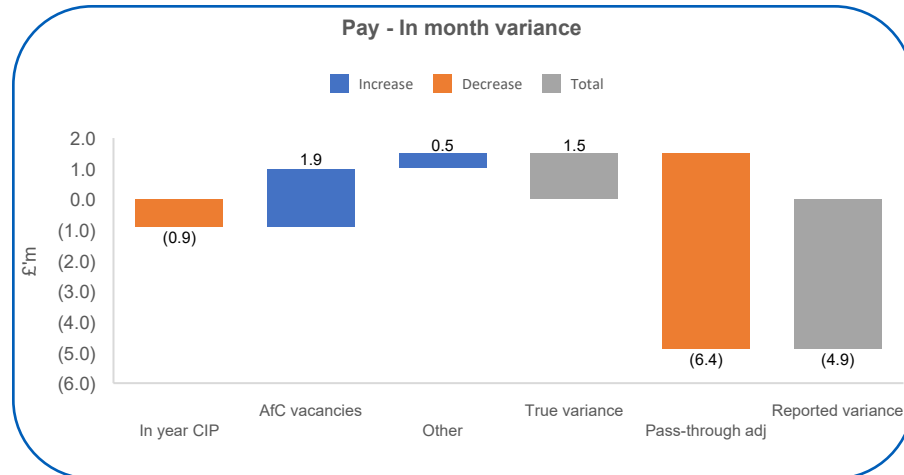
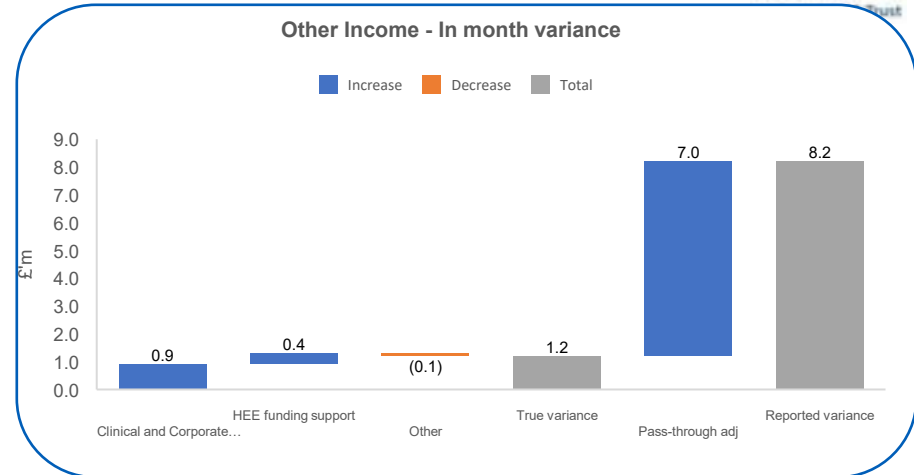
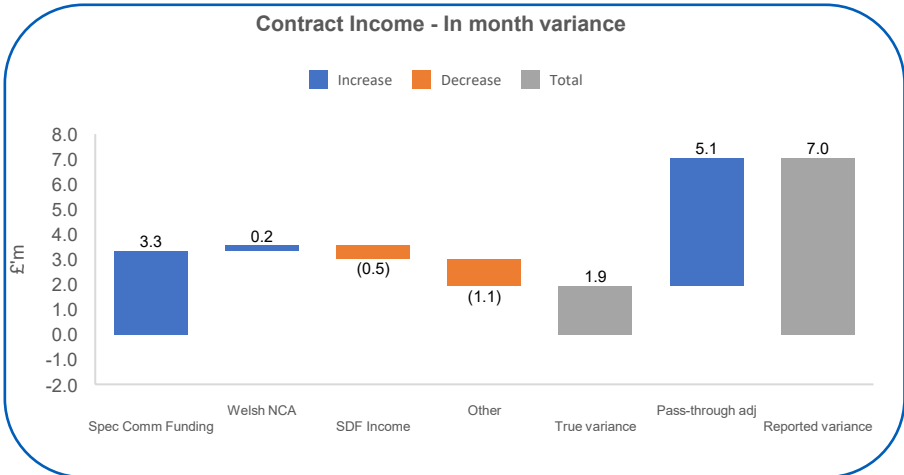
- Capital expenditure of £28.5m is required in the final month of the year in order to utilise the Trust's full allocation. Plans are in place for this expenditure, however this constitutes a large proportion of annual capital spend.
- In year, whilst pay costs year to date exceed plan, new controls introduced in August have delivered a reduction in agency and bank spend from August to February. These measures need to continue to deliver for the remainder of the financial year.
- Continued focus on delivering in year savings and containing non-pay spend are also required to ensure breakeven.

# Income and Expenditure: In month I&E waterfall



# Income and Expenditure: Year to date I&E waterfall



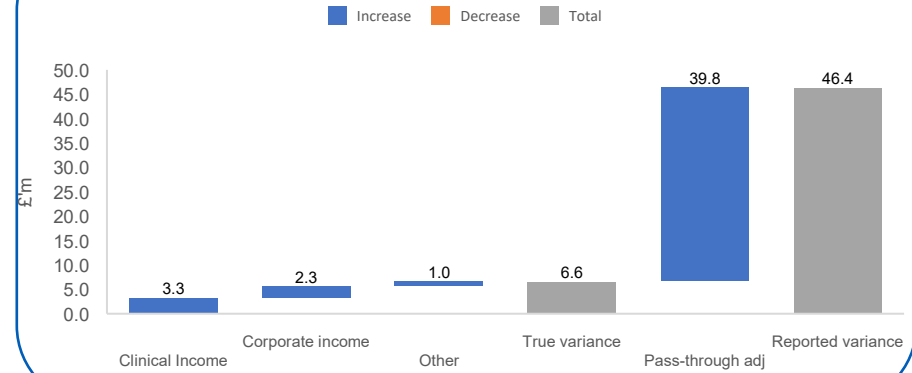


\*Note: Further explanation of variances are provided on slides 8-11

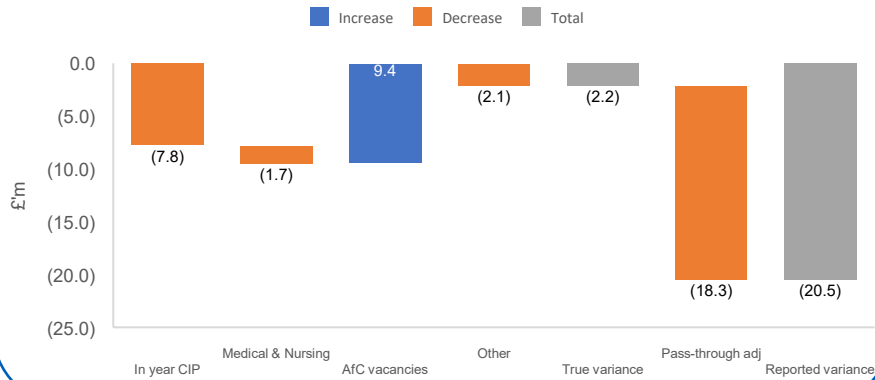
### Contract Income - YTD variance



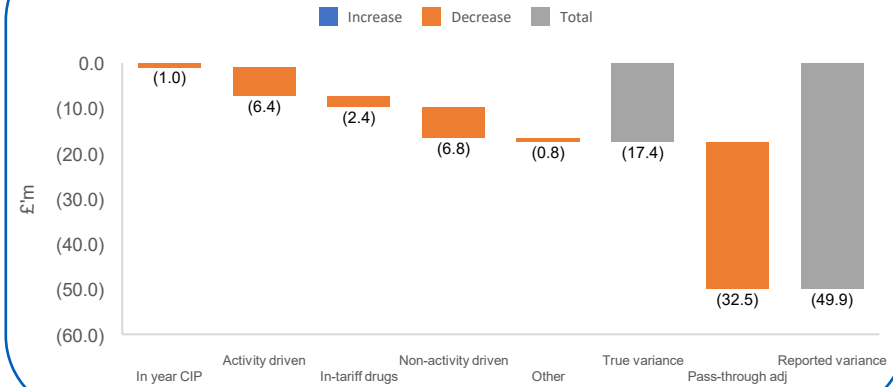
### Other Income - YTD variance



### Pay - YTD variance



### Non-pay - YTD variance



\*Note: Further explanation of variances are provided on slides 8-11

## Finance Summary Pass through adjustments to reported variance

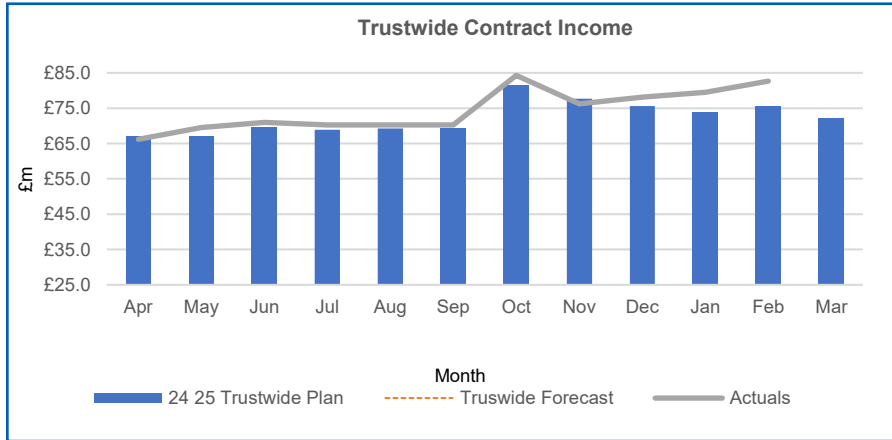
	In month				
	Contract Income	Income	Pay	Non pay	Total
	£m	£m	£m	£m	£m
<b>Reported variance</b>	<b>7.0</b>	<b>8.2</b>	<b>(4.9)</b>	<b>(8.9)</b>	<b>1.5</b>
<b>Adjustments to remove:</b>					
NHS Plan adjustments	0.0	8.8	(8.0)	(1.3)	(0.5)
Research & Education funding	0.0	(0.0)	0.0	0.0	0.0
High cost drugs	0.1	0.0	0.0	(0.1)	0.0
HCTED	0.0	0.0	0.0	0.0	0.0
Pay award	0.0	(1.6)	1.6	0.0	0.0
Other	5.0	(0.1)	0.0	(4.8)	0.1
<b>True variance</b>	<b>1.9</b>	<b>1.2</b>	<b>1.5</b>	<b>(2.8)</b>	<b>1.8</b>

	Year to date				
	Contract Income	Income	Pay	Non pay	Total
	£m	£m	£m	£m	£m
	<b>22.9</b>	<b>46.4</b>	<b>(20.5)</b>	<b>(49.9)</b>	<b>(1.0)</b>
NHS Plan adjustments	0.0	38.7	(23.7)	(15.0)	0.0
Research & Education funding	0.0	(1.0)	0.2	0.9	0.0
High cost drugs	3.7	0.0	0.0	(3.7)	0.0
HCTED	1.1	0.0	0.0	(1.1)	0.0
Pay award	0.4	(0.3)	(0.1)	0.0	0.0
Other	5.8	2.4	5.3	(13.5)	(0.0)
<b>True variance</b>	<b>11.9</b>	<b>6.6</b>	<b>(2.2)</b>	<b>(17.4)</b>	<b>(1.0)</b>

- The tables above highlight items within the position that have an equal and offsetting impact within income and expenditure or are removed to make the explanation of the variances easier to understand.
- As these have minimal effect on the position they are removed when explaining the in month and year to date variances.
- These values reconcile to the 'pass-through' items on the waterfall graphs in the preceding two slides.



# Contract Income Overview



## Contract Income

In month: £7.0m fav

YTD: £22.9m fav

### In month

- The in-month Contract Income position is £7.0m favourable to plan.
- The in-month variance is driven by £5.1m of pass-through income which includes high-cost drugs and devices and additional funding offset by expenditure. Other upsides include additional income received from Spec Comm for winter pressures and group (£3.3m) along with Welsh patient activity (£0.2m).

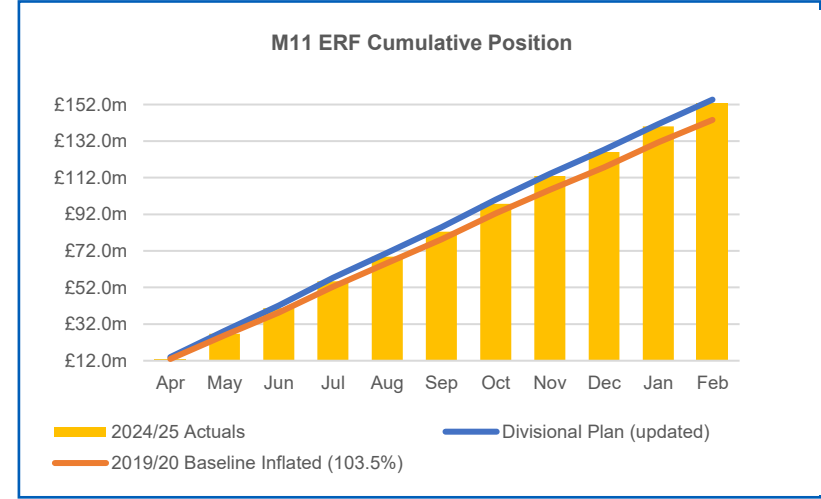
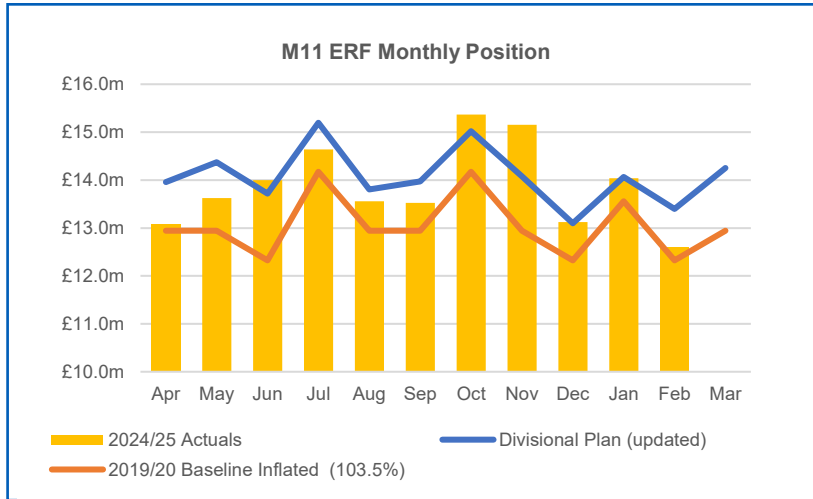
### Year to date

- Year to date, the Contract Income position is £22.9m favourable to plan.
- This is driven by additional pass-through income of £11.0m, which relates to additional Spec Comm funding, high cost drugs and devices, HCTED, an uplift to the final Genomics contract and industrial action funding. In addition, £4.6m of income relating to prior year contract settlements has been recognised in month 9 and the remaining upside is largely driven by additional service development funding received from the ICB and Spec Comm.

## Trend Analysis

- The Contract Income trend shows that Month 11 is £3.1m favourable to prior month and £9.1m ahead of the YTD average. The positive variance to prior month is driven by additional Spec Comm funding recognised in Month 11 and the upside against year to date average represents final settlements relating to prior year along with the agreement of Associates contracts and additional service development funding.

# Elective Recovery Fund Performance



## Elective Recovery Funding

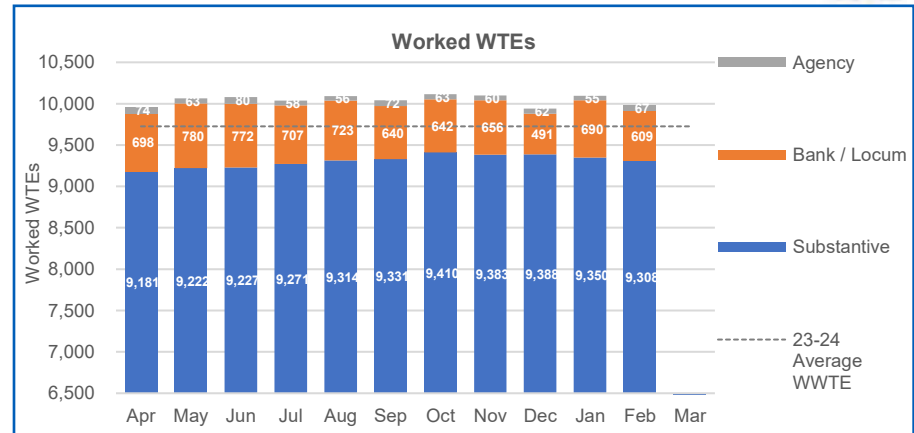
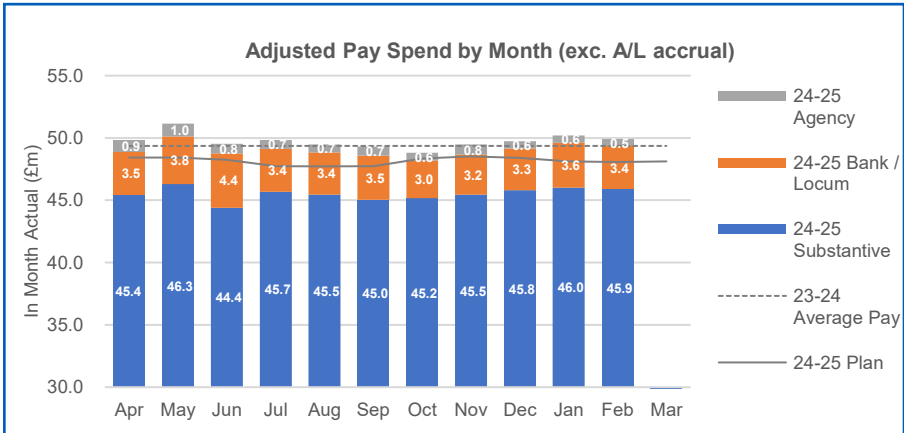
### In month

- ERF performance in February was 104.3% against 2019/20 activity.
- ERF is £0.3m greater than the agreed baselines in month but £0.8m below divisional plans due to activity variances against plan in NMSK.

### Year to date

- Year to date ERF performance is 108.4%.
- ERF Published performance for months 1-8 is in line with estimated calculations.
- Overall ERF performance is £4.0m below divisional plans.
- NMSK continue as the driver of under-delivery on divisional performance in T&O, Spinal Surgery and Neurosurgery.

# Pay Overview



\*Note: Average 23-24 pay has been inflated for the pay awards recognised in this year and adjusted for one-offs. 24-25 Pay has been normalised for in year pay awards and adjusted for one-offs.

## Pay

In month spend: £52.4m

In month: £4.9m adv

YTD: £20.5m adv

The analysis below represents spend excluding the pay award impacts.

### In month

- Trustwide pay spend is £4.9m adverse in month, when adjusted for new funding streams, the revised pay variance is £1.5m favourable to plan. This is driven by a £0.9m adverse variance driven by under delivery against in year CIP. This is offset by Agenda for Change vacancies of £1.9m, predominantly in CCS as well as £0.5m of underspends against other smaller items.
- In month agency spend is £0.5m and bank/locum spend is £3.4m. Slides 22 and 23 in the appendix have a more detailed breakdown.

### Year to date

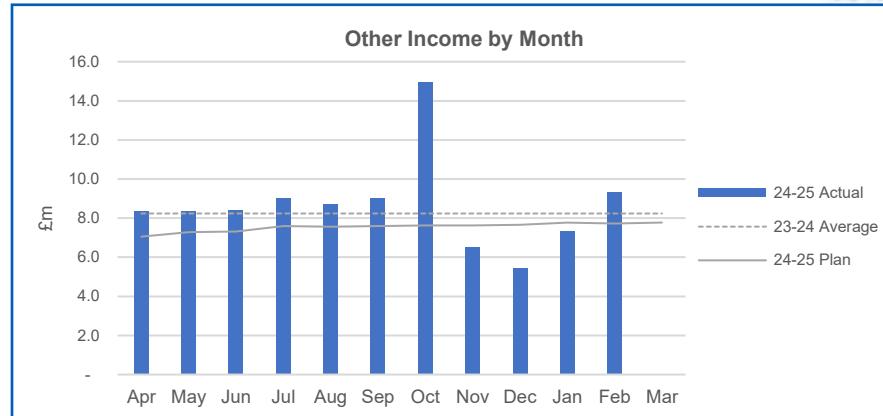
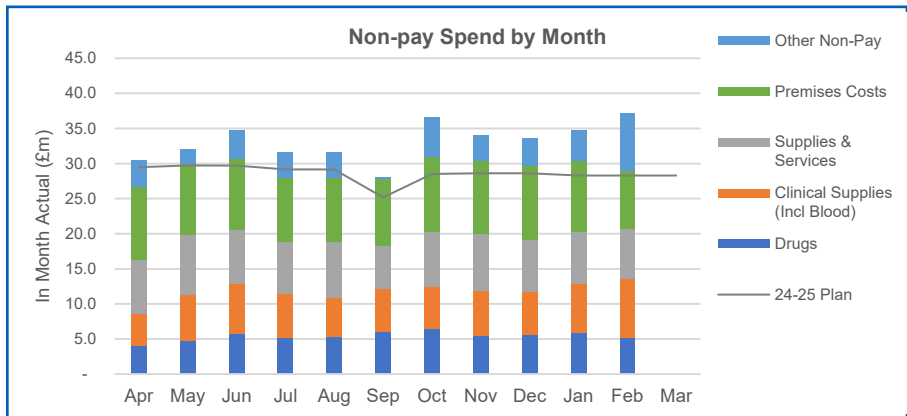
- Year to date Trust wide pay is £550.6m which is £20.5m adverse to plan. Excluding the adjustment for pass-through items, the revised position is £2.2m adverse to plan. This is driven by AfC vacancies (£9.4m favourable), predominantly within CCS. This is offset by Medical and Nursing overspends driven by pressures within the hospital (£1.7m adverse) and under delivery against in year CIP (£7.8m adverse). The remaining £2.1m adverse variance is driven by multiple smaller variances.

## Trend Analysis

(further analysis shown in the Appendix)

- When one off spend is removed in month, pay is £49.9m in February, which is a decrease of £0.3m in comparison to January. This is due to unsocial payments being paid in January as well as a reduction in bank spend due to the shorter month. WTE's in February were 9,984 compared to 10,095 in January, the decrease is driven by temporary staffing in a shorter month.

# Non pay & Non commissioned Income Overview



\*Note: Average 23-24 non-pay has been inflated by 0.8% for non-pay inflation, and adjusted for one-offs (Apprentice Levy and Stock)

**Non pay**

**In month spend: £37.2m**

**In month: £8.9m adv**

**YTD: £49.9m adv**

**In month**

- Trustwide non-pay spend is £8.9m adverse. Pass-through items are causing an adverse variance of £6.1m. The revised variance is therefore £2.8m adverse. This is driven by overspends on consumables of £0.6m adverse due to volume increases with activity. In month non-activity non-pay is £0.9m adverse driven by backdated invoices of £0.4m within CCS.

**Year to date**

- Year to date Trustwide non-pay is £364.9m, £49.9m adverse to plan. Excluding pass-through items, the revised position is £17.4m adverse. This adverse position is driven primarily by consumables which are £6.4m adverse as activity has increased. £6.9m of the adverse variance is driven by items such as IT, Bristol Ambulance costs and UKHSA activity. In tariff drugs are £2.4m adverse to deliver increased elective and non-elective activity. The remaining variances are driven by CIP (£1.0m adverse) and smaller overspends within the Corporates division, including inflation on IT contracts.

**Non NHS Income**

**In month income: £9.3m**

**In month: £8.2m fav**

**YTD: £46.4m fav**

**In month**

- In month, non-commissioned income was £9.3m creating a £8.2m favourable variance. The favourable position was driven primarily by £7.0m new funding adjustments. The remaining £1.2m favourable variance is driven by activity increases in CCS backdated to April (£0.4m) and HEE income (£0.4m). The remaining £0.4m income relates to increases in income across divisional positions such as Saplings nursery and other CCS activity.

**Year to date**

- Year to date non-commissioned income is £95.5m creating a £46.4m favourable variance. This is due to new funding in the year-to-date position since the final plan was signed off in May and pass through items (£39.8m). The remaining £6.6m favourable variance is driven by increased income across the clinical divisions due to catch-up of prior period invoicing and additional activity (£3.3m favourable) and medical education income within corporates (£2.3m favourable). The remaining £1.0m favourable variance is driven by private patient income and inflation which will be offset in pay and non-pay.

## Savings

Summary Division (£ m)	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
ASCR	5.8	4.0	0.0	0.1	4.2	(1.6)	0.0	4.2
CCS	4.8	3.6	0.0	0.0	3.6	(1.2)	0.0	3.6
MED	4.1	2.3	0.0	0.4	2.7	(1.5)	0.0	2.7
NMSK	3.7	2.7	0.0	0.2	2.9	(0.9)	0.0	2.9
WCH	1.6	1.2	0.0	0.0	1.2	(0.5)	0.0	1.2
FAC	2.5	1.4	0.0	0.2	1.7	(0.8)	0.0	1.7
Corp	5.9	5.6	0.0	0.1	5.7	(0.2)	0.0	5.7
Central	0.3	0.2	0.0	0.0	0.2	(0.0)	0.0	0.2
<b>Total</b>	<b>28.7</b>	<b>21.1</b>	<b>0.0</b>	<b>0.9</b>	<b>22.1</b>	<b>(6.6)</b>	<b>0.0</b>	<b>22.1</b>

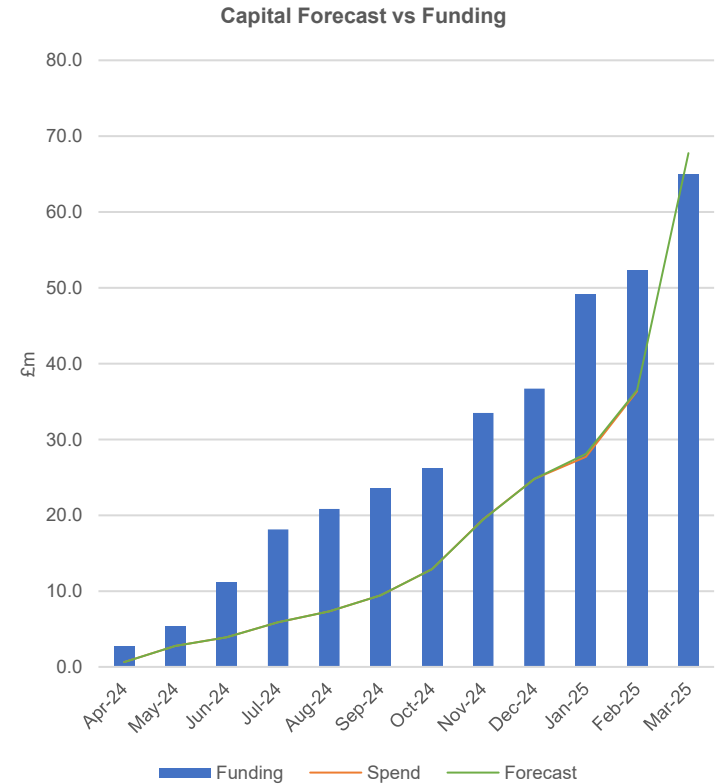
Saving Phasing £ m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Plan phasing	1.5	1.5	1.7	2.5	2.5	2.5	2.5	2.5	2.5	3.0	3.0	3.0	28.7
Delivery	0.6	0.7	2.7	1.5	3.6	3.2	1.1	1.3	1.7	1.2	3.5		21.1
Cumulative Plan	1.5	3.0	4.7	7.2	9.7	12.2	14.7	17.2	19.7	22.7	25.7	28.7	28.7
Cumulative Delivery	0.6	1.3	4.0	5.5	9.1	12.3	13.5	14.7	16.4	17.6	21.1		17.6

- The CIP plan for 2024/25 is for savings of £28.7m with £25.7m planned to be delivered by Month 11.
- At Month 11 the Trust has £21.1m of completed schemes on the tracker. There are a further £0.9m of schemes in implementation and planning, leaving a remaining £6.6m of schemes to be developed.
- The total identified CIP schemes on the tracker, with pipeline included, would deliver £6.6m less than the target.
- The table above reflects the delivery to date of £21.1m of savings in 2024/25. This is the full year effect figure that will be delivered recurrently. Due to the start date of CIP schemes this creates a mis-match between the 2024/25 impact and the recurrent full year impact.
- At Month 11 the Trust is showing a £8.8m adverse variance for delays due to in year delivery of CIP, which reflects the fact that schemes delivered by Month 11 are not currently impacting the year-to-date position.

£ m	Plan	Delivery	Variance
Recurrent Impact	25.7	21.1	(4.6)
Year to Date Impact	25.7	16.9	(8.8)

## Capital

Expenditure	FY Funding (£m)	FY Forecast (£m)	FY Forecast Variance (£m)	YTD Spend (£m)
Divisional Schemes	3.8	4.8	0.9	3.0
CRISP Schemes	3.7	3.6	(0.1)	1.0
IM&T Schemes	2.7	5.8	3.1	2.6
Medical Equipment	3.2	7.9	4.7	2.1
Sustainability Schemes	2.2	1.6	(0.6)	0.2
<b>Core Spend</b>	<b>15.5</b>	<b>23.6</b>	<b>8.1</b>	<b>8.8</b>
HCID Doors PDC	0.1	0.1	(0.0)	0.0
Digital Pathology PDC	1.0	0.7	(0.3)	0.4
Digital Imaging PDC	0.0	0.2	0.2	0.0
IR Lab 4 Replacement Bi Plane PDC	1.6	1.6	0.0	1.6
Critical Infrastructure Risk PDC	4.5	2.4	(2.1)	1.5
Cyber Security PDC	0.2	0.2	0.0	0.2
IMS PDC	0.1	0.1	0.0	0.0
Surgical Robot PDC	2.4	2.3	(0.1)	0.0
MRI Acceleration PDC	0.0	0.0	0.0	0.0
NEEF Sustainability PDC	2.3	2.3	0.0	0.0
<b>Subtotal</b>	<b>27.6</b>	<b>33.4</b>	<b>5.8</b>	<b>12.5</b>
Elective Centre	37.3	31.5	(5.8)	23.9
<b>Total</b>	<b>64.9</b>	<b>64.9</b>	<b>0.0</b>	<b>36.4</b>
Charity & Grant Funded	0.5	0.5	0.0	0.4
Leases	6.8	6.8	0.0	0.2
PFI Lifecycle	1.5	1.5	0.0	1.1
<b>Grand Total</b>	<b>73.6</b>	<b>73.6</b>	<b>0.0</b>	<b>38.1</b>



- The capital plan is currently forecast to match spend to funding available through the Trust's core capital envelope and by national funding.
- The spend year-to-date is driven by the Surgical Centre project, £23.9m, with spend on Gate 18 MRI Scanner £1.6m (within Divisional Schemes above), IR4 Biplane £1.6m and Fire Integrity £1.5m the other projects of note.
- Medical Equipment of £2.1m has been delivered so far this year, of which £0.4m relates to the Mobile Brain Lab equipment.
- Overall spend on the Elective Centre is currently £34.5m, of which £28.8m relates to the main construction contract. Year to date spend is £23.9m, of which £21.8m is on the main construction contract.
- The high level of remaining spend is driven by the Elective Centre and both IM&T and Medical Equipment, the majority of which has been ordered but not yet delivered by the end of February.



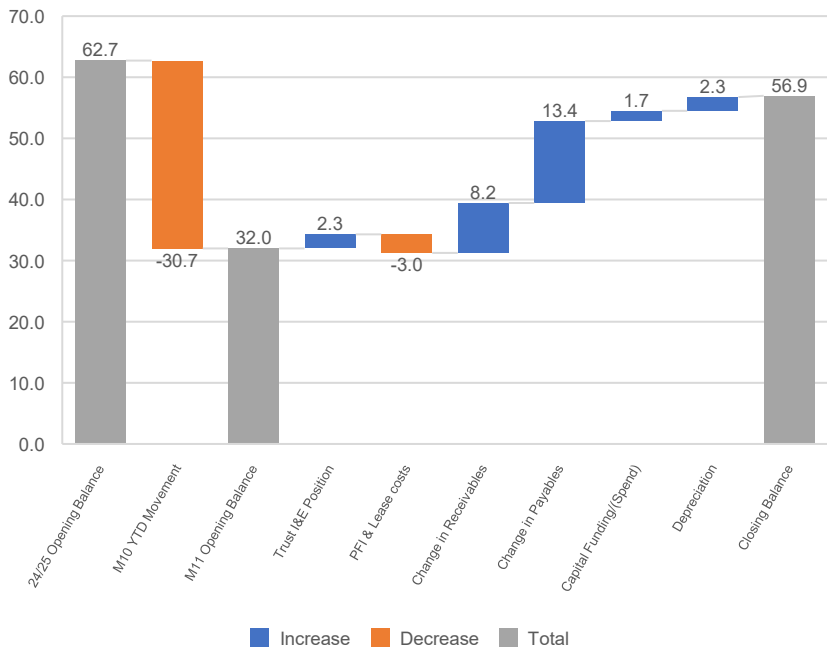
## Capital Large Project Update

Capital Project	£m					
	Approved Budget	Pre 24/25 Spend	Forecast 24/25 Spend	Forecast Future Year Spend	Forecast Total Project Spend	Variance
Southmead Elective Centre	49.9	10.5	32.2	7.2	49.9	0.0
CT Scanner	1.6	1.4	0.3	0.0	1.7	(0.1)
MRI Scanner	2.0	0.0	1.8	0.0	1.8	0.2
IR3 Biplane	1.8	1.5	0.2	0.0	1.8	0.0
IR4 Biplane	1.6	0.0	1.6	0.4	1.9	(0.4)
Fire Integrity	3.3	2.9	2.2	0.0	5.0	(1.8)
Mortuary Extension	2.3	0.2	1.9	0.0	2.1	0.2
Level 0 CT Scanners	2.2	0.0	2.0	0.3	2.3	(0.1)
PSDS Wave 3c	8.3	0.0	1.0	7.3	8.3	0.0
SSD Washer Replacement	1.4	0.0	1.1	0.0	1.1	0.3
EPMA	2.9	0.4	1.7	0.7	2.8	0.1
Cyber Security Recovery, Protection & Backup Facility	1.2	0.0	1.2	0.0	1.2	0.0
High Speed Storage	1.2	0.0	1.2	0.1	1.3	(0.1)
IM&T Equipment Refresh	1.1	0.0	1.1	0.1	1.2	(0.1)
NEEF Grant Brunel BMS	2.3	0.0	2.3	0.0	2.3	0.0

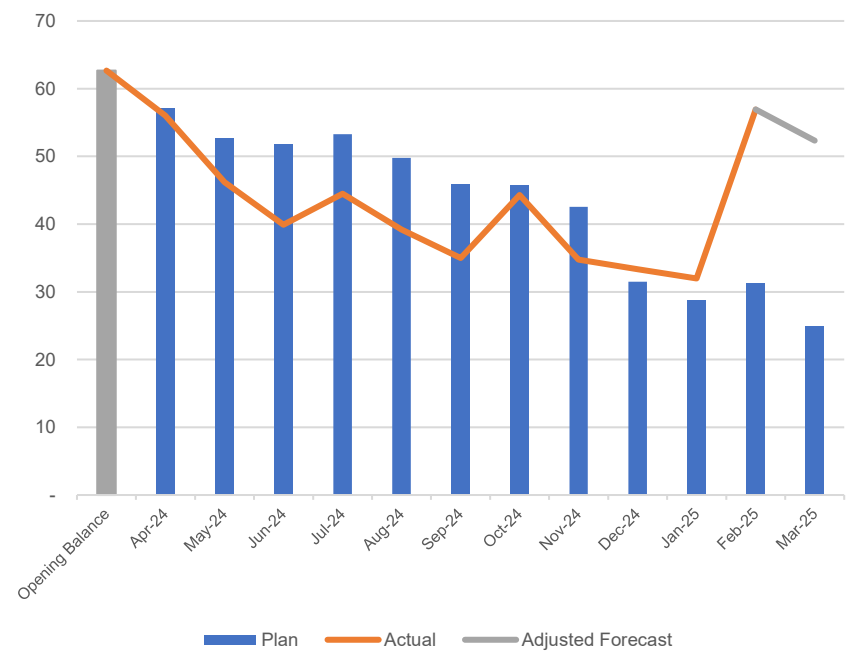
- The above table presents the current capital projects with the budget of over £1.0m.
- The adverse variances on the project to install new the CT scanners is likely to reduce when final invoice values are confirmed and these have been requested from The Hospital Company. This project are in their final stages and expected to deliver within budget.
- The business case brought for the IR4 Biplane replacement included only the cost of the equipment. A further case to cover the enabling works, scheduled for 2025/26, is expected in the early part of next year.
- Additional national funding has been secured this year to support the Fire Integrity project, as well as additional capital that has been identified in year to mitigate estates risk across various sites. The business case to support this is being brought through the next Business Case Review Group.
- An additional business case to support the EPMA project was taken through governance processes last month to increase the overall budget.
- Small variances are expected against the IM&T High Speed Storage and Equipment Refresh projects due to staffing implementation costs expected for 2025/26.

# Cash Position

M11 Cash Movement



Cash Plan vs Actual and Forecast

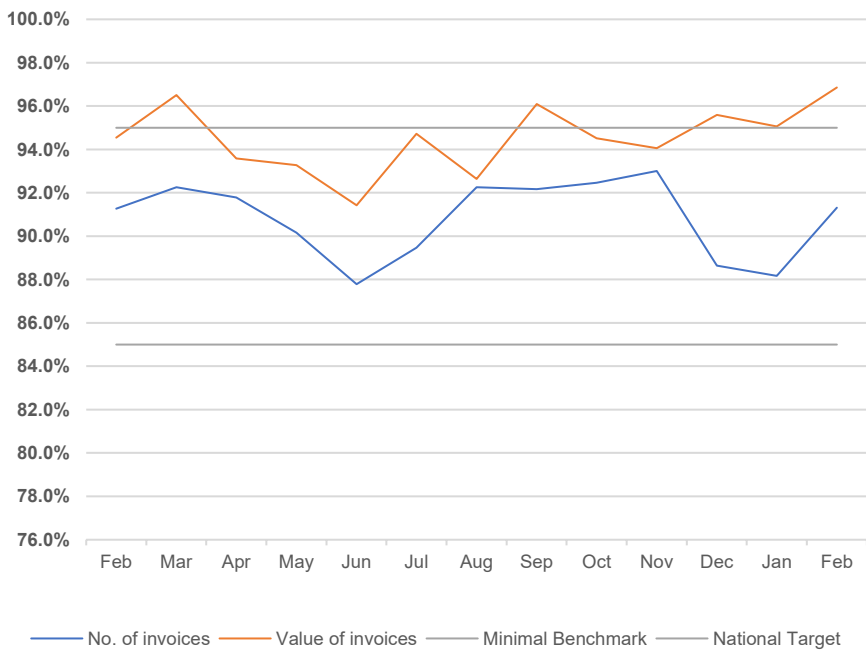


- In month cash is £56.9m, which is a £25.0m increase from Month 10 driven by a positive I&E position and movements in payables (large maintenance contracts awaiting payment) & receivables (payment of large invoices by NHSE).
- The cash balance has decreased by £5.8m year to date which is driven by the I&E deficit and capital expenditure.
- The cash position is forecast to reduce to approximately £52.3m at year end, as payables and receivables return to normal levels. This is an increase of £27.4m from plan and has increased from the forecast outturn in previous months due to further national capital cash funding.
- The cash position is expected to reduce significantly in the first months of 2025/26 due to the cash payment of the high level of capital spend expected in March.

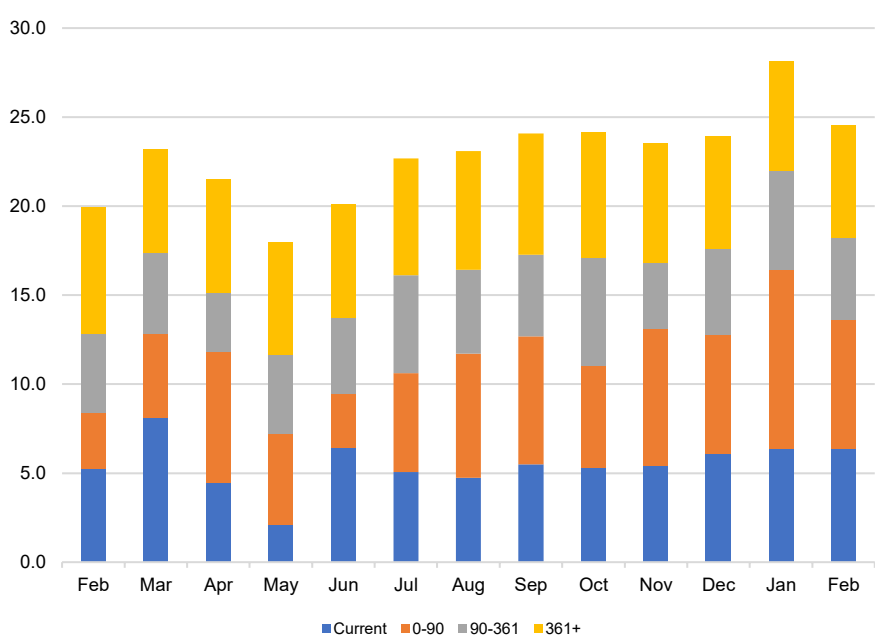
*N.B. Change in payables includes deferred income but does not include change in capital payables as this is included in capital spend. Change in Receivables also includes movements in inventories.*

# BPPC and Debt position

BPPC pass rate



Outstanding Debt



- BPPC pass rates continues to outperform minimum benchmark of 85%.
- The increase in debt in M10 was a result of outstanding debt from UHBW, which was resolved in M11.
- 61% of the debt over 361 days (£3.9m) relates to Overseas patients and is fully provided for.

### Forecast

- As a result of the adverse positions within the BNSSG acute providers in the first quarter of the year, the ICS enacted the local forecast outturn protocol.
- In NBT, a detailed forecast was undertaken at Month 3, with further reviews at Month 4 and Month 5, indicating actions were required to reduce run rates in order to achieve the breakeven plan.
- In accordance with the forecast outturn protocol, NBT has undertaken a series of actions to improve the forecast position in year:
  - **External Review**
    - External peer review completed in September.
    - Internal Audit of workforce controls completed in September – which reported to Audit and Risk Committee in October.
  - **Internal Review of Financial Controls**
    - Financial Sustainability Board continues to monitor progress against CIP targets and meet monthly.
    - Grip and Control checklist assessed and actions underway as reported to Audit and Risk Committee in August and November.
  - **Internal escalation measures**
    - In June, two divisions were put into financial escalation (Medicine and ASCR); in July, a third was added (NMSK) and in September the Facilities division also went into escalation.
    - Recruitment controls have been implemented across the Trust with all recruitment reviewed at an Executive Director or Deputy Director level depending on banding.
- These actions have allowed the Trust to mitigate an initial forecast deficit of £28.8m in June to a forecast deficit of £11.1m in September. Further additional income mitigations identified through the ICS forecast review process would bring the forecast deficit down to £6.6m.
- Following further work since September the Trust now has a route to breakeven in 2024/25. Collective action across the Trust to manage the run-rate and additional income received have helped to deliver this position.

# Risks & Mitigations

Issue	YTD Position	FOT	Risk	FOT	Mitigations	FOT	Actions
	£m	£m		£m		£m	
Under delivery of in year savings	(8.8)	(9.6)	Continued under delivery of CIP	(0.8)	Delivery of pipeline items, with CIP Board holding divisions account.	0.8	Continued organisational focus on CIP identification and delivery
Non-recurrent Income (planning assumption)	0.0	1.3					
In year surplus on pay	6.1	5.0	In year pressures continue	(0.5)	Divisional pay targets introduced	0.5	Monitor the impact of controls
In year pressures on non-pay	(11.7)	(12.9)	In year pressures continue	(1.0)	Divisional run-rate reduces	1.0	Monitor the impact of controls
Delays in investments	(0.9)	(1.7)					
Contract and Other Income	11.9	13.0					
Non-recurrent mitigations	0.5	1.9					
Other	2.0	3.0					
<b>Total</b>	<b>(1.0)</b>	<b>0.0</b>		<b>(2.3)</b>		<b>2.3</b>	

- There is a risk that the cost pressures which have arisen or increased in 2023/24, and which have not been funded externally will risk the Trust's ability to breakeven in 2024/25 if action is not taken to reduce them. TLR 1896.
- There is a risk that the savings requirement of a 3.7% recurrent delivery is not achieved in 2024/25. This is due to an insufficient level of cost releasing and productivity savings being delivered. TLR 1887.
- The Trust is actively working to mitigate the risks to delivery of a breakeven position.

- As noted in the previous slide the Trust has a breakeven position forecast for 2024/25.
- The table above highlights that there are a further £2.3m of risks within this position which are currently offset by £2.3m of mitigations.

# Appendix – Financial Statements



## Income and Expenditure: Main Heading

	Month 11			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	75.6	82.6	7.0	795.3	818.2	22.9
Other Income	1.1	9.3	8.2	49.0	95.5	46.4
<b>Total Income</b>	<b>76.7</b>	<b>92.0</b>	<b>15.3</b>	<b>844.4</b>	<b>913.7</b>	<b>69.3</b>
AHP's and STT's	(7.7)	(7.3)	0.4	(82.8)	(79.1)	3.7
Medical	(16.6)	(15.0)	1.6	(164.9)	(166.8)	(1.9)
Nursing	(18.7)	(17.8)	0.9	(199.2)	(193.7)	5.6
Other Non Clinical Pay	(4.6)	(12.4)	(7.8)	(83.2)	(111.0)	(27.8)
<b>Total Pay</b>	<b>(47.6)</b>	<b>(52.4)</b>	<b>(4.9)</b>	<b>(530.1)</b>	<b>(550.6)</b>	<b>(20.5)</b>
Drugs	(4.9)	(5.1)	(0.2)	(54.6)	(59.9)	(5.2)
Clinical Supplies (Incl Blood)	(5.7)	(8.5)	(2.8)	(59.0)	(69.9)	(10.9)
Supplies & Services	(6.9)	(7.1)	(0.3)	(71.6)	(83.3)	(11.7)
Premises Costs	(9.6)	(8.3)	1.3	(106.7)	(108.5)	(1.8)
Other Non-Pay	(1.2)	(8.2)	(7.1)	(23.1)	(43.3)	(20.2)
<b>Total Non-Pay Costs</b>	<b>(28.3)</b>	<b>(37.2)</b>	<b>(8.9)</b>	<b>(315.0)</b>	<b>(364.9)</b>	<b>(49.9)</b>
<b>Surplus/(Deficit)</b>	<b>0.8</b>	<b>2.3</b>	<b>1.5</b>	<b>(0.8)</b>	<b>(1.8)</b>	<b>(1.0)</b>

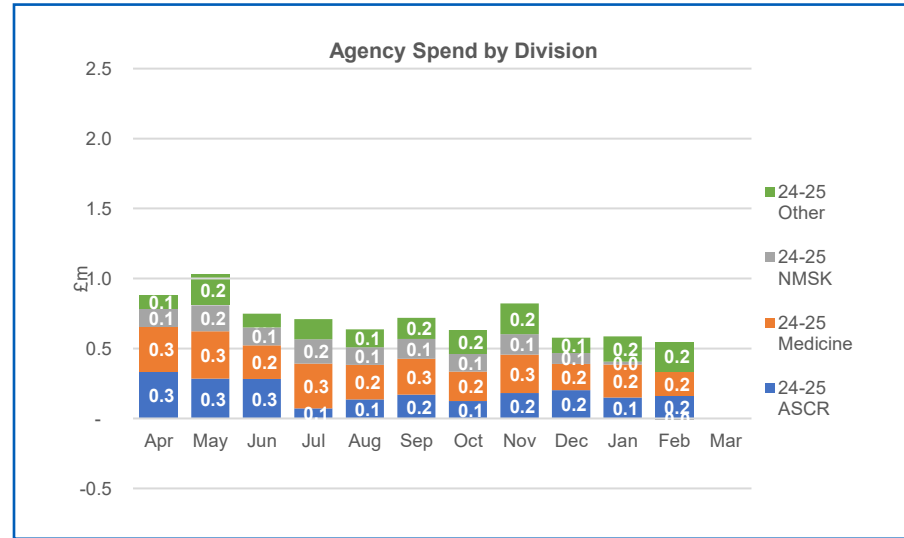
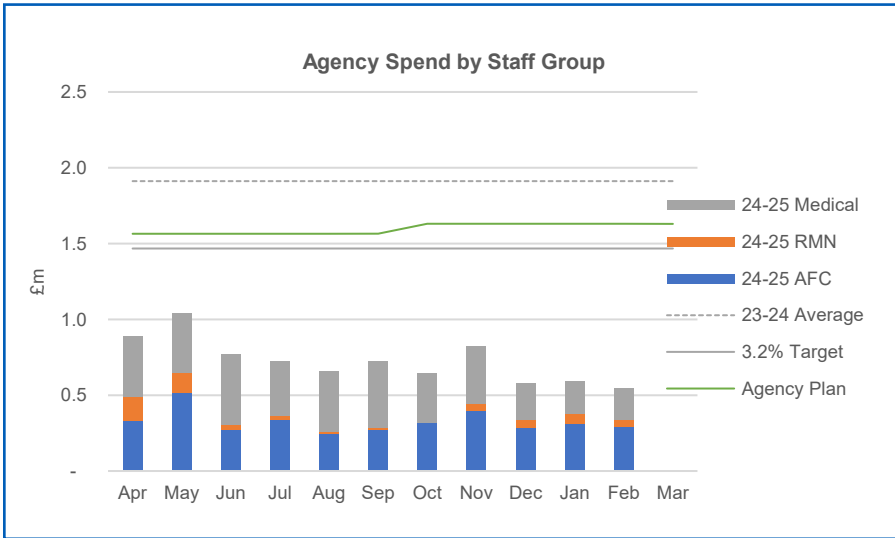
- Detailed Trustwide in month and year to date position shown by key headings. This shows further detail from the table shown on slide 2.

# Statement of Financial Position

	23/24 Month 12	24/25 Month 10	24/25 Month 11	In Month Change	YTD Change
	£m	£m	£m	£m	£m
<b>Non-Current Assets</b>	<b>538.4</b>	<b>546.0</b>	<b>552.4</b>	<b>6.4</b>	<b>14.0</b>
<b>Current Assets</b>					
Inventories	11.7	11.7	11.8	0.2	0.1
Receivables	49.4	62.0	53.7	(8.2)	4.3
Cash and Cash Equivalents	62.7	32.0	56.9	25.0	(5.7)
<b>Total Current Assets</b>	<b>123.8</b>	<b>105.6</b>	<b>122.5</b>	<b>16.9</b>	<b>(1.3)</b>
<b>Current Liabilities (&lt; 1 Year)</b>					
Trade and Other Payables	(99.9)	(78.0)	(93.6)	(15.7)	(6.3)
Deferred Income	(14.4)	(19.0)	(17.7)	1.3	3.3
Financial Current Liabilities	(23.6)	(23.6)	(23.6)	0.0	(0.0)
<b>Total Current Liabilities</b>	<b>(138.0)</b>	<b>(120.6)</b>	<b>(134.9)</b>	<b>(14.3)</b>	<b>(3.1)</b>
<b>Non-Current Liabilities (&gt; 1 Year)</b>					
Trade Payables and Deferred Income	(6.2)	(6.5)	(6.5)	(0.0)	0.4
Financial Non-Current Liabilities	(571.8)	(581.7)	(580.0)	1.7	8.2
<b>Total Non-Current Liabilities</b>	<b>(578.0)</b>	<b>(588.2)</b>	<b>(586.5)</b>	<b>1.6</b>	<b>8.6</b>
<b>Total Net Assets</b>	<b>(53.7)</b>	<b>(57.2)</b>	<b>(46.5)</b>	<b>10.6</b>	<b>7.2</b>
<b>Capital and Reserves</b>					
Public Dividend Capital	485.2	507.3	516.9	9.5	31.7
Income and Expenditure Reserve	(541.8)	(610.8)	(610.8)	0.0	(69.0)
Income and Expenditure Account - Current Year	(69.0)	(25.6)	(24.5)	1.1	44.5
Revaluation Reserve	71.9	71.9	71.9	0.0	0.0
<b>Total Capital and Reserves</b>	<b>(53.7)</b>	<b>(57.2)</b>	<b>(46.5)</b>	<b>10.6</b>	<b>7.2</b>

Items to note:
<b>Non Current Assets:</b> Movements driven by capital expenditure are offset by in-year depreciation and amortisation.
<b>Inventories:</b> Minimal year-to-date movement driven by Pharmacy.
<b>Receivables:</b> The year-to-date movement is driven by the prepayment of large value invoices for Clinical Negligence Scheme contribution and the maintenance contracts, which are expected to reduce over the year.
<b>Cash and Cash equivalents:</b> Please refer to the detailed analysis of key movements on Slide 15.
<b>Trade and Other Payables:</b> The year-to-date movement is driven by paying major year-end balances, such as business rates and capital project invoices.
<b>Deferred income:</b> The year-to-date and in-month movements follow a regular cycle of payments in advance from Health Education England, Research Grants and Commissioners.
<b>Financial Liabilities:</b> The year-to-date movement relates to movement in the PFI and lease liabilities.
<b>Income and expenditure reserve:</b> The year-to-date movement represents a rollover of the final I&E balance from the prior year.
<b>Income and expenditure account - current year:</b> The year-to-date movement represents the cumulative year-to-date I&E position including below control total items, such as annual PFI liability remeasurement of £26m.

# Pay: Temporary Staffing Agency



Note: 3.2% target is calculated based on 2024-25 budgeted pay expenditure. The final figure is based on 3.2% of 2024-25 outturn, which will not be known until Month 12.

## Agency analysis

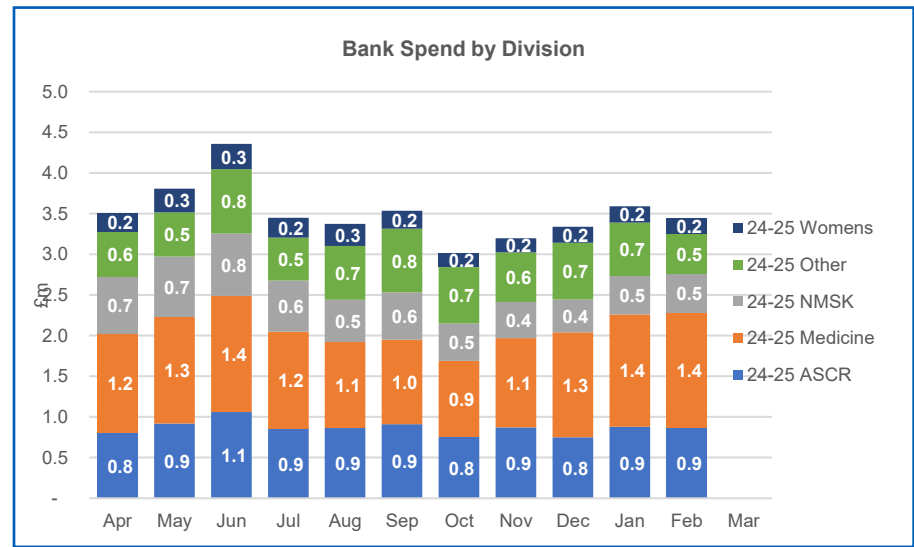
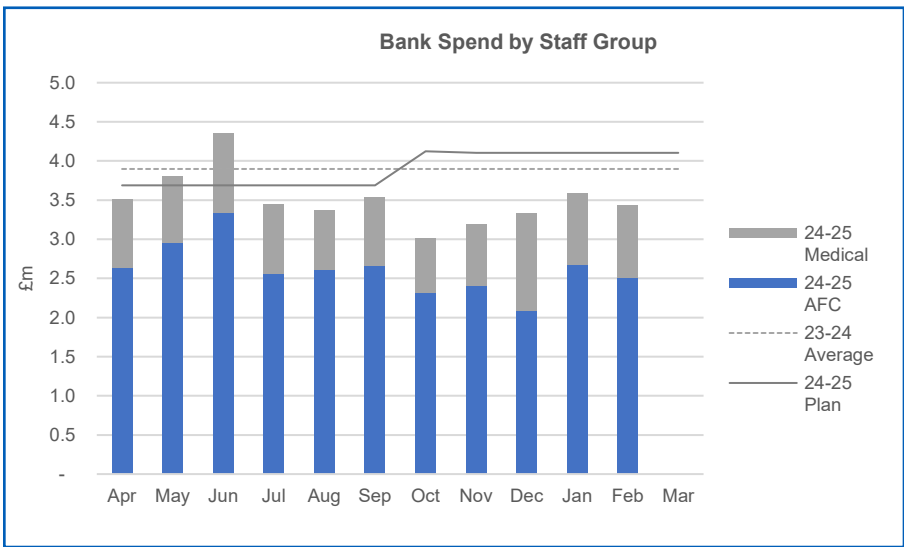
**Monthly Trend**

- Agency spend in February has stayed at a similar level to January, overall is much reduced from 2023/24 driven by the additional controls put in place. Agency usage on critical care has gone down to previous levels after increased tier 4 usage during December due to escalation and enhanced care requirements.
- Against the 3.2% Agency target the Trust is at 1.1% in month and cumulatively the Trust is at 1.5%
- Overall spend in month is driven by consultant agency usage in NMSK, ASCR, and Medicine covering vacancies as well as Healthcare Scientists in Cardiology to deliver activity.

**In Month vs Prior Year**

- Trustwide agency spend in February is significantly below 2023/24 spend. This is due to increased controls being implemented across divisions as well as the introduction of the agency rate card across the region.

# Pay: Temporary Staffing Bank



## Bank analysis

**Monthly Trend**

- In February, the reduction in bank spend trend against the first quarter of the year has been maintained, following the implementation of additional Trustwide controls. This has been seen across ASCR, Medicine and NMSK. Bank spend has continued to maintain its lower trajectory with a slight decrease as February is a shorter month.
- Included in Other is the impact of Locums Nest arrangements, where the Trust’s doctors work shifts for other local providers. These costs are recharged and so do not represent additional cost to the Trust. These costs have seen a reduction in month.

**In Month vs Prior Year**

- Bank spend in month is lower than 2023/24 spend. This is driven by decreases in escalation across the clinical divisions, and the application of additional Trustwide controls.

## Meeting of the Board on 27 March 2025 held in Public

<b>Reporting Committee</b>	<b>Audit and Risk Committee</b>
<b>Chaired By</b>	<b>Shawn Smith, Non-Executive Director</b>
<b>Executive Lead</b>	<b>Elizabeth Poskitt, Interim Chief Finance Officer</b>

For Information
<p>1. The Audit and Risk Committee met on 6 March 2025.</p> <p>2. The Committee reviewed the following internal audit review reports:</p> <ul style="list-style-type: none"> <li>• <b>Financial Systems:</b> Internal Audit had issued a positive report, concluding with a “satisfactory” assurance rating, with only minor recommendations for improvement on low-to-moderate-risk issues.</li> <li>• <b>Risk Management/Board Assurance Framework:</b> Internal Audit had issued a positive report, concluding with a “satisfactory” assurance rating, with only minor recommendations for improvement on low-to-moderate-risk issues.</li> <li>• <b>Patient Safety Incident Response Framework (PSIRF) Maturity Assessment:</b> Internal Audit had concluded that NBT had made reasonable progress in transitioning to the new PSIRF arrangements. There were no areas of non-compliance but the self-assessment and subsequent independent validation process had identified several domains where efforts were required to strengthen existing arrangements, to support the embeddedness and maturity of patient safety. It was clear that the Trust was an example of good practice, but a lack of evidence in some areas (possibly due to the Trust being an early adopter of PSIRF and therefore some historical records not being available) affected the findings.</li> </ul> <p>3. The Committee reviewed a management response to the PSIRF maturity assessment, which informed them of areas where NBT’s view diverged from that of Internal Audit. The Committee noted that work was progressing to address the areas of divergence identified and that the gaps were about lack of evidence due to historical record keeping, and not indicators of poor patient safety.</p> <p>4. The Committee also received and reviewed the following reports:</p> <ul style="list-style-type: none"> <li>• <b>External Audit Plan for the year ending 31 March 2025:</b> this notified the Committee of the components of the upcoming external audit and key issues and risks contributing to the plan. The Committee discussed key elements of the plan, including the valuation of land and buildings, and noted the increase in the materiality value (up from £12.55m in 2023-24 to £18m in 2024-25). They also noted the good progress against prior year audit recommendations.</li> <li>• <b>Internal Audit Progress Report</b> and action tracker, along with monthly insight reports and updates on service-specific audits (see section 2 above). The Committee noted that progress on all internal audits and audit findings was positive and that only four target dates were overdue. The Senior Audit and Assurance Manager commented that this was “outstanding” compared to most other Trusts.</li> </ul>

- **Draft Head of Internal Audit (HoIA) Opinion:** the Committee noted that the draft HoIA opinion on the internal control, governance and risk management arrangements for NBT at this stage (with caveats about requiring further information from completed audits and third-party assurance on the ESR system, expected in May) was that the Trust provides “strongly satisfactory” assurance. Subject to that further later work, this opinion may improve further to “significant” assurance over the next few weeks.
- **Draft Internal Audit and Assurance Plan 2025/26:** the Committee noted and agreed the draft Internal Audit and Assurance Plan for the year ahead.
- **Counter Fraud Progress Report:** the Committee noted the work undertaken for the period November 2024 to February 2025, including proactive work (e.g. training, newsletters, alerts, fraud prevention notices etc) and reactive work (e.g. investigations).
- **Draft Counter Fraud Workplan 2025/26:** the Committee noted and agreed the draft Counter Fraud Workplan for the year ahead.
- **Risk Management Report,** including updates on Trust Level Risks and the Board Assurance Framework (see BAF attached at **Appendix 1**). The Committee was informed of the successful risk deep-dives with clinical divisions and reviews by relevant committees of the ten longest-standing risks within their remits. These would be ongoing, as would the work underway to align risk appetite, policies and processes with UHBW where appropriate. The Committee welcomed the evidence of improved triangulation of risks (e.g. the recent escalation of risk 1704 (Stroke) to the Board by the Quality Committee).
- **Bristol and Weston Procurement Consortium (BWPC) Update:** the Committee received the regular BWPC dashboard, with data on compliance, single tender actions (STAs), purchase orders (POs) and non-PO spend, along with an update on the implementation of the new purchasing system, SAP Ariba. The Committee was informed of challenges experienced with data importing and cleansing, when SAP Ariba went live, due to the massive complexity and necessarily speedy implementation of the switch to SAP Ariba from EROS. The issues had impacted controls at go-live but this had been turned around and controls and vetting procedures were now much stronger. A post-implementation analysis was taking place internally to ensure lessons were learned and an internal audit was anticipated in the new financial year.
- **National Cost Collection (NCC) pre-submission report:** the Committee was informed that the 2023/24 NCC data had been published in November 2024. The 2023/24 NCC Index for NBT was 121. The guidance had been amended in respect of the treatment of accounting standards relating to IFRS 16 and this had negatively affected the Trust’s position, in terms of the cost of the Brunel building and use of space within it. The true underlying position, without the PFI, would be 113. The Committee noted the data and approved the processes in place to complete the mandated submissions for 2024/25 in line with NHS England’s approved costing guidance.
- **Grip and Control Update:** the Committee was informed of the good progress being made to ensure best practice was in place in the five Grip and Control



domains. They noted that actions in 8 of the 9 high priority areas were complete and moved to business as usual, with the 9<sup>th</sup> underway. Medium priority actions would be the next focus.

- **Losses and Overpayments at 31 January 2025:** these were noted. The Committee discussed the need to continue with efforts to minimise losses and overpayments (e.g. to ensure staff leaver forms were submitted on time).
- **External Agency Visits bi-annual update:** the Committee received an update on external regulatory agency visits to the Trust as part of the process of assurance, that any issues raised by these agencies were appropriately dealt with. They noted that most instances were green or amber-rated.
- **Declarations of Interest bi-annual update:** the Committee received an update on declarations of interest received, including declarations of gifts and hospitality, the positive action taken (such as increased cross-checks and awareness-raising) since the follow-up audit of conflicts of interest in Autumn 2023, which had resulted in significantly increased numbers and quality of declarations, and planned minor alterations to the declaration of interests policy, including alignment with UHBW's policy. The Committee noted the robust processes in place and the relationship with the Nolan principles of public life.

5. The Committee did not identify any specific areas requiring escalation to the Trust Board.

#### For Board Awareness, Action or Response (including risks)

Nothing specific.

#### Key Decisions and Actions

The Board is recommended to note this report for assurance purposes, note the activities undertaken by the Audit and Risk Committee on behalf of the Board and review and note the Board Assurance Framework attached as **Appendix 1** to this report.

#### Additional Chair Comments

None

**Date of next Audit and Risk Committee meeting:**

Thursday 8 May 2025.

# Board Assurance Framework (BAF)

## Introduction

The following document is the Trust’s Board Assurance Framework (BAF) for 2024/25. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust’s objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

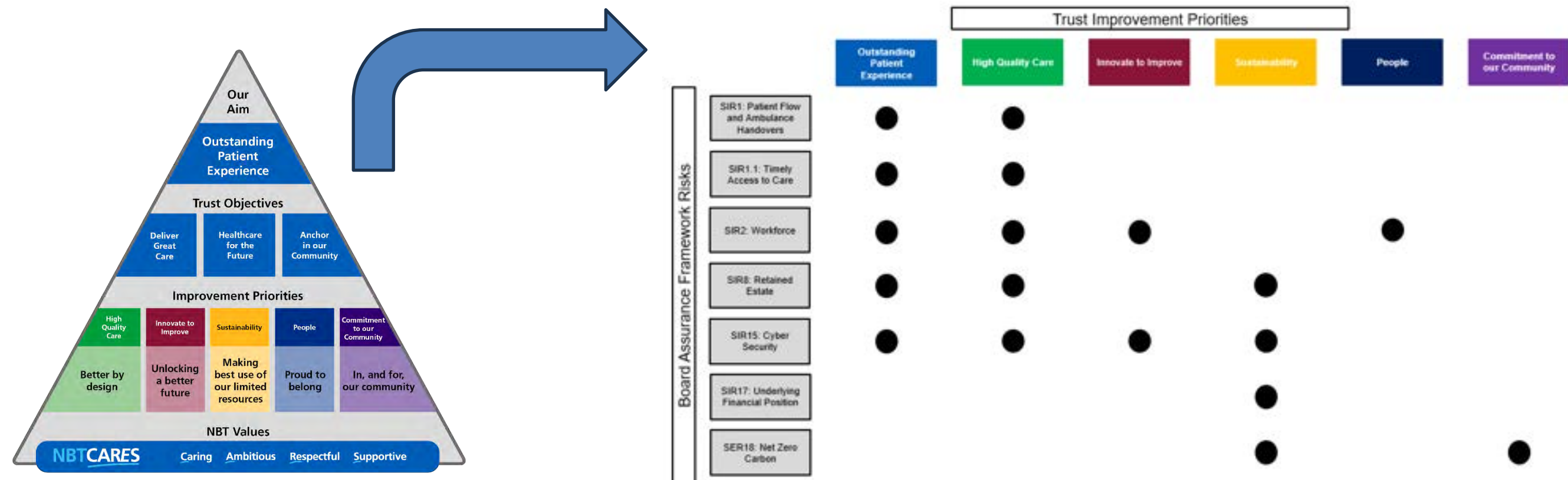
- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director’s assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit & Risk Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust’s control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

BAF Risks should be kept under review regularly, with a formal review and update mandated ahead of each meeting of the Audit & Risk Committee (meeting quarterly)

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

### BAF Risk alignment with Trust Strategic Objectives & Improvement Priorities:

This shows the primary alignment of our BAF risks with key organisational objectives and improvement priorities, noting that the risks have wide ranging implications which sit across all priority areas.



## Board Assurance Framework (BAF)

---

### Version Control (2023/24):

Version:	Summary of changes:	Reported to:
V1.0	Undertaking full BAF update for the beginning of 2023/24 – alignment to Patient First Trust Objectives and risk update	Audit Committee August 2024
V1.1	BAF now includes Carbon Neutral Risk, and alignment to key Trust Level Risks	Trust Board August 2024
V1.2	Quarterly update to BAF	Audit Committee November 2024
V1.3	Quarterly update to BAF	Audit Committee March 2025

# Board Assurance Framework (BAF)

## Risk Score Trend and Trajectories

Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)	Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)
SIR1	16	<p>Patient flow &amp; Ambulance Handovers:</p>		SIR 1.1	20	<p>Timely Access to Care:</p>	
SIR2	25	<p>Workforce:</p>		SIR15	15	<p>Significant cyber attack takes out the Trust's systems</p>	
SIR8	12	<p>Retained Estate:</p>		SIR17	15	<p>Underlying Financial Position</p>	
SIR 18	12	<p>Net Zero Carbon</p> <p>Trend TBC</p>		<p>Assurances set out for each risk in the Board Assurance Framework are categorised in line with the 'three lines of defence' model of risk management:</p> <p><b>Key:</b></p> <ul style="list-style-type: none"> <li>(1) First line - Functions that own and manage risks</li> <li>(2) Second line - Functions that oversee risks</li> <li>(3) Third line - Functions that provide independent assurance</li> </ul>			

# Board Assurance Framework (BAF)





<b>Impacting Trust Strategic Objectives:</b>	<div style="background-color: #4a7ebb; color: white; padding: 5px; display: inline-block;">Deliver Great Care</div> <div style="background-color: #4a7ebb; color: white; padding: 5px; display: inline-block; margin-left: 10px;">Healthcare for the Future</div>	<b>Impacting Patient First Improvement Priorities:</b>	<div style="background-color: #4a7ebb; color: white; padding: 5px; display: inline-block;">Outstanding Patient Experience</div> <div style="background-color: #00a651; color: white; padding: 5px; display: inline-block; margin-left: 10px;">High Quality Care</div>
--	---	--	---

**Linked Trust Level Risks:**  
 Datix 1940 – Performance Risk in Operations – Risk of poor patient flow

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 1	<p><b>Steve Curry, Chief Operating Officer</b></p> <p>Last reviewed: 17/02/2025</p> <p>Lead Committee: <b>Finance &amp; Performance Committee</b></p> <p>Also monitored by: <b>Quality Committee</b></p> <p>Last reviewed: QC 14/01/2025 FPDC 23/01/2025</p> <p>Risk added to BAF: <b>Pre-2019</b></p>	<p><b>Patient flow &amp; Ambulance Handovers:</b></p> <p>Due to a combination of factors, primarily high number of patients with no criteria to reside, but also including constrained community and primary care capacity and workforce pressures, the flow of patients across the hospital is constrained. This results in delays to key targets within the Emergency Zone, including the timely treatment of patients and delayed ambulance handovers. In turn this has the potential to result in patient harm, poor patient experience, and reputational damage to the Trust. Note: Elements of this risk are outside of the Trust's direct control – actions are focused on those areas that are within the organisation's influence.</p> <p><b>EXTERNALLY AND INTERNALLY DRIVEN RISK</b></p>	<p>Inherent likelihood: <b>5 (Almost certain)</b></p> <p>Inherent impact: <b>5 (Catastrophic)</b></p> <p>Inherent risk rating: <b>25 (Extreme)</b></p>	<p><b>Internal:</b></p> <p>FLOW boards (real-time bed state)</p> <p>Criteria to Reside data</p> <p>Integrated Discharge Service</p> <p>Repatriation Policy</p> <p>UEC Board and Improvement Plan</p> <p>OPEL/ICI Escalation &amp; COVID-19 surge policies/procedures</p> <p>Accountability Framework Divisional Review assessment of and support to Divisions.</p> <p>Internal Professional Standards</p> <p>Clinically led dynamic risk assessed approach to pre-emptive transfers out of the emergency department</p> <p>Winter bed capacity contingency plans approved.</p> <p>Transfer of Care Hub</p> <p><b>External:</b></p> <p>Whole System Operational Group (WSOG – external)</p> <p>OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group)</p> <p>Engagement with National UEC Improvement Team</p> <p>Discharge to Assess</p> <p>Winter pressure funding mechanisms</p> <p>UEC improvement plan</p> <p>Same Day Emergency Care (SDEC) Model</p>	<p><b>Internal Assurance</b></p> <p>Board rounds and site management processes <sup>(1)</sup></p> <p>Integrated Performance Report <sup>(2)</sup></p> <p>Patient flow metrics – daily control centre information <sup>(1)</sup></p> <p>Executive Team review of dashboards <sup>(2)</sup></p> <p>Performance report to Finance &amp; Performance Committee <sup>(2)</sup></p> <p>Finance &amp; Performance Committee deep-dives into operational performance (ongoing 2024/25) <sup>(2)</sup></p> <p>QC Deep dives into patient harm <sup>(2)</sup></p> <p>Divisional Performance Reviews <sup>(2)</sup></p> <p>UEC Board <sup>(2)</sup></p> <p><b>External Assurance</b></p> <p>Urgent &amp; Emergency Care Steering Group (external) <sup>(2)</sup></p> <p>System Delivery &amp; Operational Group (external) <sup>(2)</sup></p> <p>CQC 2019 inspection – Urgent and Emergency Services rated Good <sup>(3)</sup></p>	<p>Residual likelihood: <b>4 (Likely)</b></p> <p>Residual impact: <b>4 (Severe)</b></p> <p>Residual risk rating: <b>16 (Severe)</b></p> <p>Previous residual risk rating: <b>5x4=20</b></p> <p>Residual risk rating last changed: <b>08/07/2021 13/07/2023</b></p> <p>Forecast trajectory (next 12 months): </p>	<p>Not yet seeing evidence that investment in “Discharge 2 Assess” initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (led by BNSSG/Sirona).</p> <p>Other actions:</p> <p>Lack of progress on system ambition to reduce NC2R levels to ≤15%</p>	<p>Working with ICS via the system Chief Executive group and the D2A Board to identify bridging strategies and short term mitigations to compensate for delayed D2A impact. (e.g., Transfer of care hub – see below)</p> <p><b>Update:</b> D2A still not delivering as planned. Ongoing review via System-led D2A Board. Remains under regular review.</p> <p><b>Owner: Various (COO &amp; CEO)</b></p> <p><b>Delivery date: April 2025</b></p> <p>Ongoing escalation via the ICS to secure temporary additional community capacity to relieve pressures.</p> <p>Ongoing over December 2024-March 2025.</p> <p>July 2024 Update: Initiated new work with analysis on capacity gaps in out of hospital services (including LAs). Agreed a revised NCTR percentage reduction at system level. Currently working through capacity funding options to service the new ambition.</p> <p>October 2024 Update: Ongoing discussions about resourcing</p>	<p>Target likelihood: <b>3 (Possible)</b></p> <p>Target impact: <b>4 (Severe)</b></p> <p>Target risk rating: <b>12 (High)</b></p>

## Board Assurance Framework (BAF)

								<p>demand and capacity gap. Some capacity released but does not yet match demand.</p> <p>February 2025: 15% reduction has not yet been achieved and will be part of the ongoing discussions with ICS and incorporated into the NBT operational plan as an assumption, and the wider system plan as a system goal for 2025/26.</p> <p><b>Owner:</b> COO &amp; Chief Executive</p> <p><b>Due Date:</b> Summer 2025.</p>
--	--	--	--	--	--	--	--	---

<b>Impacting Trust Strategic Objectives:</b>		 		<b>Impacting Patient First Improvement Priorities:</b>		 			
<b>Linked Trust Level Risks:</b> Datix 1436 – Performance Risk in ASCR – 65-week waits in Breast Plastic Surgery Datix 1681 – Service Delivery Risk in CCS – Risk of end-of-life imaging equipment Datix 988 – Performance Risk in Operations – Risk to timeliness of cancer care Datix 523 – Patient Safety Risk in ASCR – Risk to timely follow-up appointments in Urology									
Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 1.1	Steve Curry, Chief Operating Officer	<b>Timely Access to Care</b> The impact of the Covid-19 pandemic, together with	Inherent likelihood: <b>5</b>	<b>Internal:</b> FLOW boards Integrated Discharge Service	<b>Internal Assurance</b> Board rounds and site management processes <sup>(1)</sup>	Residual likelihood: <b>4 (Likely)</b>	Not yet seeing evidence that investment in “Discharge 2 Assess” initiative is delivering planned improvements to	<b>Update:</b> D2A still not delivering as planned. Ongoing review via System-	Target likelihood: <b>3 (Possible)</b>

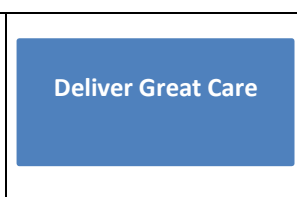
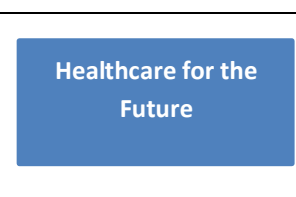
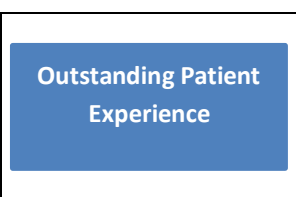
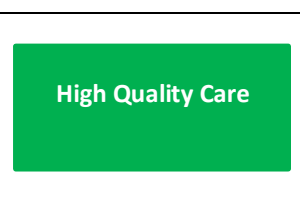
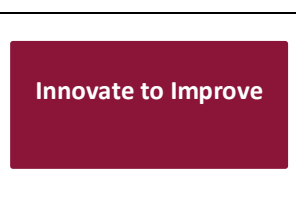
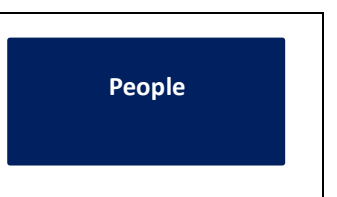


## Board Assurance Framework (BAF)

<p>Last reviewed: 17/02/2025</p> <p>Lead Committee: <b>Finance &amp; Performance Committee</b></p> <p>Also monitored by: <b>Quality Committee</b></p> <p>Last reviewed: QC 14/01/2025 FPDC 23/01/2025</p> <p>Risk added to BAF: <b>January 2022</b></p>	<p><b>high numbers of patients with no criteria to reside, workforce/skills shortages, and complex clinical pathways, has resulted in a demand/capacity gap in cancer services, diagnostics, and planned care. This has the potential to result in long-waiting patients deteriorating and coming to harm, poor patient experience, and reputational damage to the Trust.</b></p> <p>Note: drivers of this risk are outside of the organisation's direct control actions are focused on those areas that are within the organisation's influence.</p> <p>EXTERNALLY DRIVEN RISK</p>	<p><b>(Almost certain)</b></p> <p>Inherent impact: <b>5</b> <b>(Catastrophic)</b></p> <p>Inherent risk rating: <b>25</b> <b>(Extreme)</b></p>	<p>Repatriation Policy</p> <p>OPEL/ICI Escalation &amp; COVID-19 surge policies/procedures</p> <p>Accountability Framework</p> <p>Internal Professional Standards</p> <p>Protected Elective Capacity.</p> <p>Use of WLI</p> <p>Use of independent sector</p> <p>Clinical Long-wait Harm Review Process (no wait related harm identified)</p> <p>Fortnightly Cancer Steering Group</p> <p>Cancer Improvement Plan</p> <p>Compliant Diagnostics Improvement Plan</p> <p>RTT Recovery Plan</p> <p>Agile and responsive IPC controls</p> <p>Well-rehearsed contingency process for managing immediate impacts of industrial action (i.e., safety heat-map, strike period booking avoidance etc.)</p> <p>Ring-fenced surgical capacity since 2022</p> <p>Community Diagnostics Centre Capacity</p> <p>Long-term workforce plans</p> <p>Well-developed and tested industrial action planning process.</p> <p>Secured extension of Park View operating theatres until the opening of the Surgical Centre.</p> <p><b>External:</b></p> <p>Whole System Operational Group (WSOG – external)</p> <p>OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group)</p> <p>Elective Recovery Fund Access (system-wide)</p> <p>EPRR metallic structures to oversee Industrial action (meeting commensurate with strike action)</p>	<p>Integrated Performance Report <sup>(2)</sup></p> <p>Patient flow metrics – daily control centre information <sup>(1)</sup></p> <p>Executive Team weekly review of dashboards <sup>(2)</sup></p> <p>Performance report to Finance &amp; Performance Committee <sup>(2)</sup></p> <p>Finance &amp; Performance Committee deep-dives into operational performance ongoing in 2024/25 <sup>(2)</sup></p> <p>QC Deep dives into patient harm <sup>(2)</sup></p> <p>Accurate Wating List Models <sup>(2)</sup></p> <p>Divisional Performance Reviews <sup>(2)</sup></p> <p>Trust Board presentations on Planned Care Trajectories, Cancer Performance 2022 <sup>(2)</sup></p> <p><b>External Assurance</b></p> <p>System Delivery &amp; Operational Group (external) <sup>(2)</sup></p> <p>National Tier 1 Cancer Escalation Status removed in December 2022 <sup>(3)</sup></p>	<p>Residual impact: <b>4</b> <b>(Severe)</b></p> <p>Residual risk rating: <b>16</b> <b>(High)</b></p> <p>Previous residual risk rating: 5x4=20</p> <p>Residual risk rating last changed: 17/02/2025</p> <p>Forecast trajectory (next 12 months): </p>	<p>discharge numbers (led by BNSSG/Sirona), to allow increased surgical activity.</p>	<p>led D2A Board. Remains under regular review.</p> <p>Longer term recovery relies on Community Diagnostics Centre and exploring opportunities for additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (October 2024: the CDC is now online and will be moved to the “controls” section of this risk).</p> <p>Bristol Surgical Centre due to come online in May 2025.</p> <p>July 2024 Update: Bristol Surgical Centre Plans on track and activity transfer agreed with UHBW.</p> <p>October 2024: delay in build has pushed back go-live date to May 2025</p> <p>February 2025: revised estimate for delivery of Surgical Centre in early summer.</p> <p><b>Owner: COO</b> <b>Due Date: August 2025</b></p>	<p>Target impact: <b>4</b> <b>(Severe)</b></p> <p>Target risk rating: <b>12</b> <b>(High)</b></p>
---	---	---	---	--	---	---	---	---

### Board Assurance Framework (BAF)

--	--	--	--	--	--	--	--	--	--

<b>Impacting Trust Strategic Objectives:</b>				<b>Impacting Patient First Improvement Priorities:</b>				
<b>Linked Trust Level Risks:</b> Datix 1979 – Workforce Risk (CSS/ASCR) – Shortage in certain specialist medical roles								

## Board Assurance Framework (BAF)

Datix 1699 – Patient Safety (Medicine) – Absence of a Core24 Mental Health Service									
Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 2	<b>Peter Mitchell, Interim Chief People Officer</b>  Last reviewed: 13/02/2025  <b>People Committee</b>  Last reviewed: 16/01/2025  Risk added to BAF: Pre-2019	<b>Workforce</b> Due to healthcare workforce shortages at a national level, exacerbated by the local high cost of living, workforce demand is outstripping supply in key areas, including nursing, midwifery, and specialist consultant roles. This gives rise to the risk of: - Increased workload intensity leading to staff turnover, - Uncontrolled spend on expensive agency/temporary staff, - Increase in recruitment activity and associated costs, - Poor staff morale, and - Poor patient safety & experience.  Elements of this risk are outside of the Trust's direct control (numbers of professionally registered medics and other specialists controlled via HEE national quotas and royal colleges) – actions are focused on those areas that are within the organisation's influence.	Inherent likelihood: <b>5 (Almost Certain)</b>  Inherent impact: <b>5 (Catastrophic)</b>  Inherent risk rating: <b>25 (Extreme)</b>	NBT Long Term Workforce Strategy & Plan (refreshed March 2024)  People Oversight Group and sub-structure approved via People Committee and Trust Board in 2023.  Retention interventions underpinned by Patient First Improvement Priority delivering a 1 and 5 year retention plan  Long-term Retention Plan 2024  Award-winning, nationally recognised Staff Health & Wellbeing offering  Staff experience initiatives including Buying & selling annual leave policy, expanded flexible working offer.  EDI Plan and Anti-racism work Strong development and leadership offer (HELM)  Increased opportunities through HELM Programme  Staff Health Strategy – including staff health checks.  Increased use of traineeship and apprenticeships.  Collaborative recruitment and shared bank with UHBW including faster recruitment processes and system wide recruitment Financial wellbeing offering (overseen by Culture & Wellbeing working group).	<b>Internal Assurance</b> Integrated Performance Report – HR/Well-Led section <sup>(2)</sup>  People Committee deep-dives and performance review (quarterly) <sup>(2)</sup>  Staff survey results & action plans <sup>(2)</sup>  Exit interview data <sup>(1)</sup>  Pulse Surveys <sup>(1)</sup>  Freedom to Speak Up Reports <sup>(2)</sup>  Triangulation Group Reports <sup>(1)</sup>  Trust Board People Deep-dive March 2023 <sup>(2)</sup>  Trust Board Safe Staffing Deep-dive April 2023 <sup>(2)</sup>  Six-monthly update on Long Term Workforce Plan to Trust Board <sup>(1)</sup>  <b>External Assurance</b> Gender pay-gap report and WRES/WDES data <sup>(3)</sup>  National Retention Data <sup>(3)</sup>  Staff Survey Results <sup>(3)</sup>  NHS England Workforce Plan 2023 <sup>(3)</sup>	Residual likelihood: <b>4 (Likely)</b>  Residual impact: <b>3 (Possible)</b>  Residual risk rating: <b>12 (High)</b>  Previous residual risk rating: 4x3=12 4x4=16 3x4=12 5x4=20 5x5=25  Residual risk rating last changed: 24/10/2024 12/08/2020 05/10/2021 05/01/2023 23/04/2024  Forecast trajectory (next 12 months): 	There is potential competition between providers within the BNSSG ICS and the wider South West for the same staff, and there are identified differentials in grading between similar roles.  There are insufficient trained staff in certain professions (including nursing, sonographers, histopathologists etc.) to meet ongoing and increasing needs.	The People Benefit Strand of the Hospital Group Benefits Case will focus on ensuring aligned and complementary workforce arrangements between the two Acute Trusts and across the wider system.  <b>Owner: Chief People Officers</b> <b>Due date: March 2026</b>  Talent acquisition team are providing targeted support to affected specialties.  <b>Delivery date: Throughout 2025</b> <b>Owner: CPO</b>	Target likelihood: <b>3 (Possible)</b>  Target impact: <b>4 (Severe)</b>  Target risk rating: <b>12 (High)</b>

## Board Assurance Framework (BAF)

<b>Impacting Trust Strategic Objectives:</b>		<div style="display: flex; justify-content: space-around;"> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Deliver Great Care</div> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Healthcare for the Future</div> </div>		<b>Impacting Patient First Improvement Priorities:</b>		<div style="display: flex; justify-content: space-around;"> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Outstanding Patient Experience</div> <div style="background-color: #00a651; color: white; padding: 5px; text-align: center;">High Quality Care</div> <div style="background-color: #ffc000; color: white; padding: 5px; text-align: center;">Sustainability</div> </div>			
<b>Linked Trust Level Risks:</b>									
Datix 1587 – Service Delivery Risk in Facilities – Pathology Chiller Failure									
Datix 1572 – Service Delivery Risk in Facilities – Pathology Air Handling Unit									
Datix 1946 – Service Delivery Risk in WACH – Condition of WACH Estate									
Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 8	<b>Elizabeth Poskitt, Interim Chief Finance Officer</b>  Last reviewed: 19/02/2025	<b>Retained Estate</b> <b>Parts of the retained estates are aging and approaching the point where significant refurbishment is required. Without decant facilities or alternative provision this</b>	Inherent likelihood: <b>4 (Likely)</b>  Inherent impact:	Capital Planning Group & sub-structure 10-year Estates Capital Plan (CRISP) Interim Estates Plan 2022 Health & Safety Committee & policies	<b>Internal Assurance</b> Capital Planning reports to Finance & Performance Committee (twice-yearly) <sup>(2)</sup> Health & Safety reports to People Committee, and Control of Infection	Residual likelihood: <b>3 (Possible)</b>  Residual impact:	The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all	Capital funding has been received to complete chiller replacement and upgrades for the Pathology building in 2025. Electrical upgrades within W&C's also planned to be completed early 2025	Target likelihood: <b>2 (Unlikely)</b>  Target impact:

## Board Assurance Framework (BAF)

	<p><b>Finance &amp; Performance Committee</b></p> <p>Last reviewed: 23/01/2025</p> <p>Risk added to BAF: <b>Pre-2019</b></p>	<p><b>work cannot be undertaken in a proactive manner, exposing the Trust to the risk of unplanned service failure/delivery, and associated degradation of patient safety, operational performance, and patient/staff experience.</b></p> <p>Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk.</p> <p>INTERNALLY DRIVEN RISK</p>	<p><b>5 (Catastrophic)</b></p> <p>Inherent risk rating:</p> <p><b>20</b></p> <p><b>(Extreme)</b></p>	<p>H&amp;S subject matter sub committees</p> <p>Preventative Maintenance Programme</p> <p>Facilities help-desk (to advise on any deterioration of estate)</p> <p>Executive and Board Insight walk-arounds</p> <p>Expected capital programme slippage used as a contingency for unexpected works in the retained estate</p> <p>Up-to-date Fire Safety Policy and Fire Safety Manager oversight</p> <p>2023/24/25 Capital Plan approved prioritising significant fire and ventilation remediation spend</p> <p>Shared (jointly appointed) Strategic Estates Director between NBT and UHBW</p>	<p>Committee (bi-monthly (quarterly + annual report) <sup>(2)</sup></p> <p>2022 Fire Safety Audit Actions progress reported to People Committee <sup>(3)</sup></p> <p>Fire and ventilation risks are understood and recorded on a granular (building) level, with individual remediation plans. <sup>(3)</sup></p> <p>Compliance Governance committees reviewing risks and incidents; COIC, Water Safety Group, Ventilation Safety Group, Electrical Safety Group, Fire Safety Group <sup>(2)</sup></p> <p>ERIC/Model Hospital Benchmarking confirms relative position to other Trusts backlog status (annual process) <sup>(2)</sup></p> <p>Fire risk audits undertaken regularly across the site <sup>(1)</sup></p> <p>Interim Estates Plan 2022 <sup>(1)</sup></p> <p>Report to Finance &amp; Performance Committee on Retained Estates Trust Level Risks and mitigations – September 2023. <sup>(1)</sup></p> <p>Health &amp; Safety Internal Audit Report – Green Amber Rating – provides assurance of robust oversight function. <sup>(3)</sup></p> <p><b>External Assurance</b></p> <p>Six Facet Survey completed 2020 <sup>(3)</sup></p> <p>Four facet survey planned to be completed early 2025</p>	<p><b>4 (Severe)</b></p> <p>Residual risk rating:</p> <p><b>12</b></p> <p><b>(High)</b></p> <p>Previous residual risk rating: <b>N/A</b></p> <p>Residual risk rating last changed: <b>N/A</b></p> <p>Forecast trajectory (next 12 months):</p> <p></p>	<p>other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded.</p> <p>There is a growing concern that due to the nature of the improvement works that are needed in the retained estate that there will be a need to decant buildings to facilitate this work namely, Pathology, NICU, CDS and Gynae Theatres. These works are mainly related to ventilation improvement works and chiller replacement.</p> <p>Revised System capital allocation and prioritisation processes had added complexity and delay to capital planning and resulted in reduced capital availability.</p>	<p>The most recent Fire Risk Assessment programme will feed into ongoing annual capital programme based on most effective risk reduction.</p> <p>A specific piece of work is being completed between the Estates and the W&amp;C Divisional teams to detail the remaining risks that cannot be remediated within the available CDEL, understand the mitigation actions being undertaken and in recognition of the enhanced level of risk being accepted, detail the business continuity plans for services being delivered in these higher risk areas.</p> <p><b>Owner:</b> ICFO/Director of Operational Estates and Facilities, DOD W&amp;CH</p> <p>Elective Care Centre FBC approved nationally in September 2023. Go-live anticipated to be May 2025. While this will be focused on elective recovery, it will provide contingency in the event of catastrophic failure of other theatres and will ultimately be available for decant in year to come.</p> <p><b>Due date:</b> May 2025</p> <p><b>Owner:</b> Interim Chief Finance Officer and Interim Hospital Managing Director</p>	<p><b>4 (Severe)</b></p> <p>Target risk rating:</p> <p><b>8</b></p> <p><b>(High)</b></p>
--	--	--	--	---	--	--	---	--	--

## Board Assurance Framework (BAF)

<b>Impacting Trust Strategic Objectives:</b>		<div style="display: flex; justify-content: space-around;"> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Deliver Great Care</div> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Healthcare for the Future</div> </div>		<b>Impacting Patient First Improvement Priorities</b>		<div style="display: flex; justify-content: space-around;"> <div style="background-color: #4a7ebb; color: white; padding: 5px; text-align: center;">Outstanding Patient Experience</div> <div style="background-color: #00b050; color: white; padding: 5px; text-align: center;">High Quality Care</div> <div style="background-color: #ffcc00; color: white; padding: 5px; text-align: center;">Sustainability</div> <div style="background-color: #800040; color: white; padding: 5px; text-align: center;">Innovate to Improve</div> </div>			
<b>Linked Trust Level Risks:</b>									
Datix 545 – Service Delivery Risk in IMT – Risk of overheating data centre									
Various other sub-TLR (12+) risks reported to Finance & Performance Committee in line with Board Risk Appetite Statements.									
Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score



## Board Assurance Framework (BAF)

<p>SIR 15</p>	<p><b>Neil Darvill, Director of IM&amp;T</b></p> <p>Last reviewed: 23/07/2024</p> <p><b>Finance &amp; Performance Committee</b></p> <p>Last reviewed: FPDC 18/07/2024</p> <p>Risk added to BAF: <b>Pre-2019</b></p>	<p><b>Cyber Security</b></p> <p><b>A significant cyber-attack results in the loss of all Trust IT systems for an extended period leading to a failure of business continuity and the inability to treat patients.</b></p> <p>Note: while this risk is externally driven, there are elements of the risk that the trust can control through mitigations and additional back-up/protection.</p> <p>EXTERNALLT DRIVEN RISK</p>	<p>Inherent likelihood: <b>5 (Almost Certain)</b></p> <p>Inherent impact: <b>5 (Catastrophic)</b></p> <p>Inherent risk rating: <b>25 (Extreme)</b></p>	<p>IT security measures such as password policies and information governance training</p> <p>Daily immutable system back-ups</p> <p>Business continuity and cyber incident recovery plans</p> <p>Timely server and software updates</p> <p>Continuous upgrades to supported versions of Windows and Microsoft 365</p> <p>Ongoing assessments of software with removal or mitigations for outdated and unsupported products</p> <p>Ongoing monitoring and software upgrades (see further information under "gaps" and "planned actions")**</p> <p>Microsoft 365 cloud-to-cloud backups for email and teams data</p> <p>Participants in NHS England cyber security alerting and briefing programmes</p> <p>Server and Network vulnerability scanners</p> <p>Microsoft Defender Endpoint (antivirus) live across Microsoft Windows estate</p> <p>BNSSG Cyber Security Governance Group aligning organisational standards and ensuring best practice.</p> <p>NHS England South West Regional Cyber Security Group for direction and access to national solutions</p>	<p><b>Internal Assurance</b></p> <p>Data security protection toolkit return ("Standards Met" 2024) <sup>(1)</sup></p> <p>Technology Services Cyber Security Working Group.</p> <p>Cyber security report (monthly to IM&amp;T Divisional Board and Audit &amp; Risk Committee) <sup>(2)</sup></p> <p>Audit Committee Assurance Report (six monthly) (March 2023, August 2023, May 2024, scheduled November 2024) <sup>(1)</sup></p> <p><b>External Assurance</b></p> <p>Information Commissioner Audit December 2019 <sup>(3)</sup></p> <p>Data security protection toolkit return (minimum "Standards Met" 2024) <sup>(1)</sup></p> <p>Penetration Tests and assessments, February 2024 <sup>(2)</sup></p> <p>KPMG Data Security Protection Toolkit Audit 2024 "significant Assurance" <sup>(2)</sup></p>	<p>Residual likelihood: <b>3 (Possible)</b></p> <p>Residual impact: <b>5 (Catastrophic)</b></p> <p>Residual risk rating: <b>15 (Extreme)</b></p> <p>Previous residual risk rating: <b>4x5=20</b></p> <p>Residual risk rating last changed: <b>22/05/2020</b></p> <p>Forecast trajectory (next 12 months): </p>	<p>**Significant work has been completed to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems.</p> <p>In 2023-2024 and 24-25:</p> <ul style="list-style-type: none"> <li>- Over 8000 end point devices upgraded to latest version of Windows 10</li> <li>- Legacy Windows 2008 servers remain eradicated</li> <li>- Further 3 Windows 2012 servers eradicated leaving five remaining all with paid for support</li> <li>- Deployment of log retention tool</li> <li>- Funding approved to refresh network and deploy micro-segmentation</li> </ul>	<p>Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity.</p> <p><b>Owner: Phil Wade</b></p> <p><b>Due Date: see below</b></p> <ul style="list-style-type: none"> <li>- Ongoing remediation work for areas highlighted by the vulnerability scanner.</li> </ul> <p>Target for change: persistent risk - ongoing</p> <p>The BNSSG Cyber Security Governance Group has approved an initial draft of the ICS Cyber Security Strategy which will be updated and published for approval to partner boards during 2025/26.</p> <p><b>Target December 2025-</b></p> <ul style="list-style-type: none"> <li>- Following the NHS Digital backup audit, we are creating a business case for funding in 2024/25 to improve or replace the existing solution.</li> </ul> <p><b>Target: June 2024</b> for business case review. – part one of business case submitted to BCRG August 24.</p> <p>Part two approved in November 24, equipment delivered in February 2025 and full deployment planning is underway.</p> <ul style="list-style-type: none"> <li>- Network micro-segmentation project to block access and restrict spread cyber attacks: project in full flight with upgrades to outdate Wireless LAN controllers completed.</li> </ul> <p><b>Target project completion March 2024;</b> the need to install additional boundary protection capacity has resulted in a delay, the target for completion is now June 2025,</p> <ul style="list-style-type: none"> <li>- Remove or mitigate 146 Windows 2012 servers from the estate; currently 5 remain all of which have paid for support until March</li> </ul>	<p>Target likelihood: <b>3 (Possible)</b></p> <p>Target impact: <b>5 (Catastrophic)</b></p> <p>Target risk rating: <b>15 (High)</b></p>
---------------	---	---	--	--	---	--	--	--	---

## Board Assurance Framework (BAF)

								<p>2025. These servers support other services that have not yet completed migrations and we continue to assist with resolution.</p> <p><b>Target completion March 2025.</b></p> <p>New planned actions:</p> <ul style="list-style-type: none"> <li>- Increase risk and audit updates from annual to six monthly (now scheduled, completed)</li> <li>- Improve email filtering using additional tools</li> </ul> <p><b>Business case submitted for consideration as part of 2024/25 business planning and is currently with Finance pending funding approval</b></p> <ul style="list-style-type: none"> <li>- Developing an assessment process with the Trust auditors to investigate cyber resilience of the supply chain with procurement.</li> </ul> <p>Report and action plan expected January 2025; this activity was paused whilst other procurement commitments were underway, a date will be rescheduled in the next financial year.</p>	
--	--	--	--	--	--	--	--	---	--

# Board Assurance Framework (BAF)

<b>Impacting Trust Strategic Objectives:</b> 		<b>Impacting Patient First Improvement Priorities</b> 							
<b>Linked Trust Level Risks:</b> Datix 1887 – Financial Risk – Risk to delivery of recurrent savings Datix 1896 – Financial Risk – Risk of unfunded cost pressures									
Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 17	<b>Elizabeth Poskitt, Interim Chief Finance Officer</b>  Last reviewed: 19/02/2025  <b>Finance &amp; Performance Committee</b>  Last reviewed: 19/09/2024  Risk added to BAF: October 2022	<u><b>Underlying Financial Position</b></u>  There is a risk that if the Trust does not deliver its planned financial position sustainably, and reduce its underlying deficit, it will be subject to increased regulatory intervention. This may include a loss of decision-making autonomy, increased scrutiny, and increased reporting requirements.	Inherent likelihood: <b>4 (Likely)</b>  Inherent impact: <b>5 (Catastrophic)</b>  Inherent risk rating: <b>20 (Extreme)</b>	<b>Internal:</b> Internal Planning Processes Divisional Reviews Business Case Review Group Financial Sustainability Reviews CIP Board oversight of plans Exceptions to Budgeted Establishment Group (EBE) Procurement controls (enhanced) Monthly Budget Monitoring “Grip & Control” reviews Financial Escalation procedures HELM Leadership Programme Engagement in regional procurement where appropriate  <b>External:</b> ICS Directors of Finance (DoF) Group System Planning Processes Monthly Financial Returns and review with NHSE System Finance & Estates Group	Monthly Finance Report (Trust Board, FPC, Exec Management Team, Senior Leadership Group) <sup>(2)</sup> Divisional Reviews <sup>(2)</sup> Weekly CIP Monitoring Reports <sup>(1)</sup> Monthly consolidated System Finance Report <sup>(2)</sup> Annual Internal Audit Report – Financial Controls <sup>(3)</sup> External Audit – Value for Money Review <sup>(3)</sup> Model Hospital Benchmarking <sup>(3)</sup> National Cost Collection Submission <sup>(3)</sup> Financial Sustainability (CIP) Board meeting monthly. Breakeven plan submitted by NBT as part of System Breakeven plan submission.	Residual likelihood: <b>3 (Possible)</b>  Residual impact: <b>5 (Catastrophic)</b>  Residual risk rating: <b>15 (High)</b>  Previous residual risk rating: <b>4x5=20</b>  Residual risk rating last changed: <b>01/03/2023</b>  Forecast trajectory (next 12 months):	2024/25 CIP and savings plans delayed in delivery.          Being at or close to funded establishment means timely delivery of CIP becomes more important and reallocating resources to meet operational needs becomes a priority to avoid incurring additional temporary staffing costs.	9% of CIP schemes remain in pipeline (rather than planning or implementation) Divisions, Transformation and Trustwide teams need to develop plans to allow them to be delivered.  <b>Delivery date:</b> 31 March 2025 <b>Owner:</b> CFO    Additional controls have been put in place to manage both substantive recruitment and committing additional temporary staffing costs. In place from August 2024 and remaining until March 2025, with further review beyond this. Delivery Date: Review March 2025 <b>Owner:</b> CFO  70% of CIP schemes for 2025/26 have been identified Divisions and Trustwide	Target likelihood: <b>2 (Unlikely)</b>  Target impact: <b>4 (Severe)</b>  Target risk rating: <b>8 (High)</b>

### Board Assurance Framework (BAF)

							<p>4%, which equates to £32.4m. However, further savings will be required to cover the 0.9% increase in the national efficiency target (£7.8m). Currently £27m plans have been identified.</p>	<p>teams need to develop plans to allow them to be delivered.</p> <p><b>Delivery date:</b> 31 March 2025</p> <p><b>Owner:</b> CFO</p>	
--	--	--	--	--	--	--	--	---	--

## Board Assurance Framework (BAF)

<b>Impacting Trust Strategic Objectives:</b>	<div style="display: flex; justify-content: space-around;"> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center;">Deliver Great Care</div> <div style="background-color: #0056b3; color: white; padding: 5px; text-align: center;">Healthcare for the Future</div> </div>	<b>Impacting Patient First Improvement Priorities</b>	<div style="background-color: #ffc107; padding: 10px; text-align: center; font-weight: bold;">Sustainability</div>
--	---	---	--

**Linked Trust Level Risks:**  
*Risk entries under review – likely to be linked to financial implications.*

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions (including owner and delivery date)	Target risk score
SIR 18	<p><b>Elizabeth Poskitt, Interim Chief Finance Officer</b></p> <p>Last reviewed: 21/02/2025</p> <p><b>Finance &amp; Performance Committee</b></p> <p>Last reviewed: 23/01/2025</p> <p>Risk added to BAF: August 2024</p>	<p><b>Net Zero Carbon</b></p> <p>The Trust will not meet the goals set out in the ICS Green Plan to achieve net zero carbon by 2030 and biodiversity net gain, leading to ecosystem collapse, additional costs from carbon taxation and offset costs, reduced health outcomes resulting from air pollution and reputational damage.</p> <p>EXTERNALLY DRIVEN RISK</p>	<p>Inherent likelihood: <b>5 (Almost Certain)</b></p> <p>Inherent impact: <b>3 (Moderate)</b></p> <p>Inherent risk rating: <b>15 (Extreme)</b></p>	<p><b>Internal:</b></p> <p>Sustainability team in Estate &amp; Facilities Dir. And close working relationship with UHBW team</p> <p>Sustainability impact assessment required in over £100k business cases.</p> <p>Carbon route map identifies Trust carbon emissions by emission sector &amp; actions to reduce carbon emissions &amp; increase biodiversity.</p> <p>Green Plan Delivery Plan defines work programme at Trust and partner level to reduce emissions and increase biodiversity.</p> <p>Appointed Sanjoy Shah the Joint Clinical Director for Green and Sustainable Healthcare to drive forward clinical sustainability projects.</p> <p>Sustainability audit template for departments to self-assess progress and benchmark against best practice.</p> <p><b>External:</b></p> <p>ICS Green Plan Steering Group (GPSG) monitors progress against Delivery Plan.</p> <p>ICS Green Plan Implementation Group (GPIG) drives actions set out in Delivery Plan.</p>	<p>Monthly Green Plan Delivery Plan highlight report to GPSG. <sup>(1)</sup></p> <p>Monthly workstream highlight reports to GPIG. <sup>(1)</sup></p> <p>Regular updates to ICS Estates Steering Group. <sup>(1)</sup></p> <p>Green Plan annual report to ICB Board and Trust Board. <sup>(1)</sup></p> <p>Greener NHS Quarterly Data Collection</p>	<p>Residual likelihood: <b>4 (Likely)</b></p> <p>Residual impact: <b>3 (Moderate)</b></p> <p>Residual risk rating: <b>12 (High)</b></p> <p>Previous residual risk rating: <b>N/A</b></p> <p>Residual risk rating last changed: <b>N/A</b></p> <p>Forecast trajectory (next 12 months): </p>	<p>Insufficient capital funding to replace fossil fuel boilers and vehicles with NZC alternatives and meet requirements of the 2025/26 NHS Standard contract. Accounting rules are a barrier to using third party funding to decarbonise.</p> <p>Insufficient capacity in Trust teams to deliver change, in particular to procurement of goods which represent 54% (58k tCO2e) of our carbon emissions.</p> <p>Insufficient focus on cultural/behavioural change as sustainable behaviour needs to be embedded in all Trust activities where possible.</p> <p>Majority of Trust transport related emissions are associated with patients and visitors so reliance is on decarbonisation of public transport.</p> <p>Slow and costly to achieve sustainable change in PFI.</p> <p>NHS focus on in-year financial savings does not enable investment in sustainable practice that costs more upfront but will save money in the long term.</p> <p>No centralised process for capturing projects that contribute to the ICS Green Plan as well as deliver savings across multiple Trust</p>	<p>Actively apply for all grant funding opportunities</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: As opportunities emerge</b></p> <p>Engage with NHSE/DHSC on solutions to accounting barriers.</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: March 2025</b></p> <p>Embed social value and carbon reduction into procurement processes.</p> <p><b>Owner: Procurement Team</b></p> <p><b>Due: September 2025</b></p> <p>Map Green Plan delivery actions to responsible owners (complete)</p> <p>Responsible owners of Green Plan Delivery actions identify relevant oversight and decision-making forums.</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: September 2025</b></p> <p>GPSG to review achievement and deliverability of key deliverables in the Delivery Plan</p> <p>Maintain transparent dialogue with staff and citizens about what is achievable and barriers to</p>	<p>Target likelihood: <b>3 (Possible)</b></p> <p>Target impact: <b>3 (Moderate)</b></p> <p>Target risk rating: <b>9 (High)</b></p>



## Board Assurance Framework (BAF)

				<p>ICS Estates Steering Group allocates capital funding to support carbon reduction schemes.</p> <p>CQC Environmental Sustainability Quality Statement required.</p> <p>Task Force on Climate-Related Financial Disclosures</p> <p>Section 18 NHS Standard Contract</p>			<p>priorities e.g. cost reduction, patient first, digitalisation, patient safety.</p> <p>Directorates and divisions are not held accountable for progress made against the ICS Green Plan.</p> <p>Green Plan/sustainability is not embedded in clinical governance.</p> <p>Carbon emissions due to purchasing goods and services is spend-based and therefore does not reflect true progress made to reduce carbon in supply chain.</p>	<p>delivery that are outside our control.</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: September 2025</b></p> <p>Provide training to relevant staff in divisions, procurement, Patient First and finance teams to identify sustainability impacts of all projects and schemes that contribute to the ICS Green Plan</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: March 2025</b></p> <p>Active engagement with THC/Equans to deliver carbon emission reductions.</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: Ongoing</b></p> <p>Forecast long-term carbon tax charges to NBT associated with the extent of NBT's removal of fossil fuels (complete)</p> <p>Build into business case financial analysis (revenue consequences of energy and carbon tax) (complete)</p> <p><b>Owner: Finance team</b></p> <p><b>Due: January 2025 (complete)</b></p> <p>Embed sustainability in patient first, procurement and CIP projects or schemes using the SIA</p> <p>Set carbon budgets and Green Plan objectives for each division/directorate. Embed progress reporting into performance reviews.</p> <p><b>Owner: Sustainability Team / DMTs</b></p> <p><b>Due: June 2025</b></p>
--	--	--	--	---	--	--	---	--



### Board Assurance Framework (BAF)

								<p>Establish Clinical Sustainability Group to provide governance and identify and secure resource to deliver sustainability projects.</p> <p><b>Owner: Sustainability Team</b></p> <p><b>Due: April 2025</b></p>	
--	--	--	--	--	--	--	--	--	--

## Board Assurance Framework (BAF)

### APPENDIX A: RISK SCORING MATRIX

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Impact Score (severity of potential harm) and its Likelihood Score (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

#### Impact Score (severity of potential harm)

	1	2	3	4	5
Risk Type	Negligible	Minor	Moderate	Severe	Catastrophic
<b>Patient Experience</b>	Unsatisfactory patient experience not directly related to patient care  Peripheral element of treatment or service suboptimal  Informal complaint/inquiry	Unsatisfactory patient experience – readily resolvable  Overall treatment or service suboptimal  Formal complaint (stage 1)  Local resolution  Minor implications for patient safety if unresolved	Mismanagement of patient care  Repeated failure to meet internal standards  Formal complaint (stage 2) complaint  Local resolution (with potential to go to independent review)  Major patient safety implications if findings are not acted on	Serious mismanagement of patient care  Multiple complaints/ independent review  Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service  Inquest/ombudsman inquiry  Gross failure of patient safety if findings not acted on
<b>Patient Safety</b>	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention.  Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention  Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity/disability  Increase in length of hospital stay by >15 days  Mismanagement of patient care with long-term effects	Incident leading to death  Multiple permanent injuries or irreversible health effects
<b>Health &amp; Safety</b>	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days  RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
<b>Workforce</b>	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
<b>Performance, Business Objectives</b>	Interim and recoverable position  Negligible reduction in scope or quality  Insignificant cost increase	Partial failure to meet subsidiary Trust objectives  Minor reduction in quality / scope  Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives  Definite reduction in scope or quality  Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met  Irrecoverable schedule slippage  Low performance rating	Trust Objectives not met  Irrecoverable schedule slippage that will have a critical impact on project success  Zero performance rating
<b>Service Delivery &amp; Business Continuity</b>	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
<b>Financial</b>	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold"  Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time  Uncertain delivery of key objective  Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow  Failure to meet specification/ slippage  Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
<b>IM&amp;T</b>	Information system issue affecting one service user	Information system issue affecting one department  Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division  Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division.  Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
<b>Reputational</b>	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days.  MP Concern (Questions in House)
<b>Statutory Duty &amp; Inspections</b>	No or minimal impact or breach of guidance/ statutory duty  Minor recommendations	Non-compliance with standards reduced rating.  Recommendations given.	Single breach in statutory duty  Challenging external	Enforcement Action  Multiple challenging recommendations	Prosecution  Multiple breaches in statutory duty

## Board Assurance Framework (BAF)

	1	2	3	4	5
<b>Risk Type</b>	Negligible	Minor	Moderate	Severe	Catastrophic
			recommendation Improvement notice	Improvement notices Critical report	Complete systems change required Severely critical report

### Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Likelihood score	1	2	3	4	5
<b>Descriptor</b>	Rare	Unlikely	Possible	Likely	Almost certain
<b>Broad descriptor</b>	This will probably never happen/recur	Do not expect it to happen/recur	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
<b>Frequency</b>	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
<b>Probability</b> <small>Will it happen or not?</small>	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The **Risk Score** is determined by the Impact x Likelihood.

Likelihood score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
<b>5 Catastrophic</b>	5	10	15	20	25
<b>4 Severe</b>	4	8	12	16	20
<b>3 Moderate</b>	3	6	9	12	15
<b>2 Low</b>	2	4	6	8	10
<b>1 Negligible</b>	1	2	3	4	5

### Risk Grade:

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk